

COMMITTEE OF THE WHOLE

11-0045R

RESOLUTION AUTHORIZING THE CITY TO ENTER INTO A JOINT POWERS AGREEMENT AND TRUST AGREEMENT WITH THE DULUTH ENTERTAINMENT AND CONVENTION CENTER, HOUSING AND REDEVELOPMENT AUTHORITY OF DULUTH AND DULUTH AIRPORT AUTHORITY TO FORM AND IMPLEMENT A JOINT POWERS ENTERPRISE, ALONG WITH APPROVAL OF THE BYLAWS OF THE JOINT POWERS ENTERPRISE.

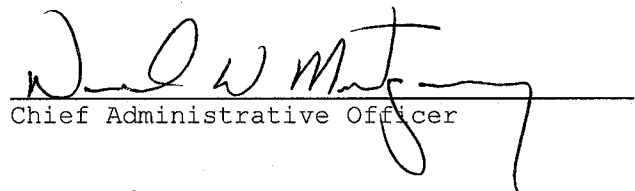
CITY PROPOSAL:

RESOLVED, that the proper city officials are hereby authorized to enter into a joint powers agreement and trust agreement to form and implement the Joint Powers Enterprise relating to the operation of a self-insurance pool under Minnesota law, substantially in the form of the copies on file in the office of the city clerk as Public Document Nos. _____ and _____, with the Duluth entertainment and convention center, housing and redevelopment authority of Duluth and Duluth airport authority, along with approval of the bylaws of the Joint Powers Enterprise, substantially in the form of the copy on file in the office of the city clerk as Public Document No. _____.


Approved:


Department Director

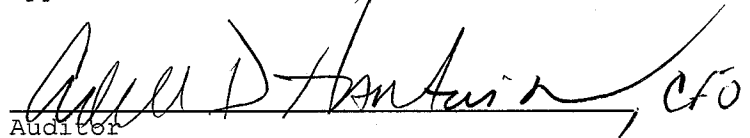
Approved for presentation to council:


Chief Administrative Officer

Approved as to form:


Attorney

Approved:


Auditor

HR/ATTY LDW:blj 1/14/2011

STATEMENT OF PURPOSE: The City maintains its active and retiree health care plan through an internal Group Health Fund. For more than 20 years, the DECC, HRA and Airport have co-participated in that plan. The firefighters Union filed a complaint with the Minnesota Department of Commerce (DOC) requesting an

investigation and determination that the City was operating a self-insurance pool subject to regulatory requirements.

The DOC determined that the Group Health Fund was a self-insurance pool subject to DOC regulatory authority and requirements. The DOC found that the current administration and operation of the pool (Group Health Fund) did not comply with MN law or the DOC's regulations. The City was ordered to take the necessary steps to get into compliance.

The City has been working with the DOC to put together the legally required governance documents to come into compliance with the regulations. At the end of December, the DOC issued its Certificate of Authority/Compliance authorizing the City to operate a self-insurance pool in accordance with the attached governance documents. The City has been ordered to comply with MN law and approval of these documents achieves that objective.

SECTION 115 TRUST AGREEMENT

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THIS TRUST AGREEMENT, made effective this 31st day of March, 2011 by and among the Members and the Trustee.

WITNESSETH:

WHEREAS, the Members have previously established and operated, on a joint basis, one or more group health plans (and may adopt additional group health plans in the future) for the purpose of providing health benefits to certain employees and former employees of the Members and their beneficiaries; and

WHEREAS, the Members have entered into a joint powers agreement (the "JPA"), which reflects their agreement to jointly maintain such group health plans; and

WHEREAS, to implement and carry out certain provisions of the JPA, the Members desire to establish a trust for the purpose of funding the group health plans currently jointly sponsored by the Members and any group health plans jointly sponsored by the Members in the future; and

WHEREAS, the Members have authority to establish a trust under Minnesota Statutes Section 471.617.

NOW, THEREFORE, the parties hereto, each in consideration of the covenants, agreements, and declarations of the other, mutually covenant, agree, and declare as follows:

**ARTICLE I.
INTRODUCTION**

- 1.1 **Establishment.** This executed Agreement constitutes the "Trust." The effective date of the Trust is March 31, 2011. The effective dates of the Plans are reflected in each Plan's governing document.
- 1.2 **Purpose.** The Members jointly provide for the security and welfare of their eligible employees (and certain others covered through those eligible employees) by the establishment and maintenance of the Plan(s) as provided in the JPA. The purposes of the Trust are (1) to provide a source of funds to pay benefits and administrative expenses under the Plan(s), and (2) to permit Trust assets to be invested and such earnings thereon to be not taxable under the Code. It is an essential function and integral part of the exempt activities of the Members to make contributions to and accumulate assets in the Trust for those purposes. The Trust is intended to qualify as a tax exempt trust under Section 115 of the Code.

ARTICLE II. DEFINITIONS

The following words and phrases are used in this Agreement and shall have the meanings set forth in this Article unless a different meaning is clearly required by the context or is defined within an Article.

- 2.1 **Agreement** means this document, which constitutes the Trust.
- 2.2 **Code** means the Internal Revenue Code of 1986, as amended from time to time.
- 2.3 **Employer Contribution** means the contributions made by Members to the Plan(s) that, under the terms of the Plan and/or the JPA, are required to be held in this Trust.
- 2.4 **Investment Account** means an account established pursuant to Section 4.1(d) for the purpose of holding certain Trust assets, the investment of which will be directed by an Investment Advisor.
- 2.5 **Investment Advisor** means an individual or entity appointed by the Trustee pursuant to Section 5.1 to direct the investment of all or a portion of the Trust assets.
- 2.6 **JPA** means the Joint Powers Agreement entered by and among the Members, effective March 31, 2011.
- 2.7 **Members** means the governmental units that are parties to the JPA. Upon the effective date of the Trust, Members include the City of Duluth, the Duluth Airport Authority, the Duluth Entertainment and Convention Center, and the Duluth Housing and Redevelopment Authority.
- 2.8 **Participant** means "Participant" as defined in the JPA.
- 2.9 **Plan(s)** means the group health or welfare plan or plans, as may be amended from time to time, that are (1) jointly sponsored by the Members pursuant to the JPA, and (2) funded through the Trust.
- 2.10 **Trust** means this Trust, created for the purpose of accepting and holding certain Employer Contributions or other contributions under the Plan(s). The Trust shall be known as the Duluth JPE Trust.
- 2.11 **Trustee** means the Board of Trustees established pursuant to the JPA. The individuals that comprise the Board of Trustees shall be appointed as provided in the JPA.

**ARTICLE III.
THE TRUST**

- 3.1 **Trust.** The assets of the Plan(s) shall be held in the Trust by the Trustee, as provided in the JPA or determined by the Board.
- 3.2 **Title of the Trust Funds.** The Trustee shall hold title to the assets of the Trust.
- 3.3 **Return of Contributions.** Notwithstanding any other provision of this Agreement, contributions made by the Members based upon mistake of fact may be returned to the Members within one year of such contribution; provided that the return of contributions under this Section 3.3 may not violate any provision of the Plan(s) or the JPA.
- 3.4 **Subaccounts.** If the Trust funds more than one Plan, then the Trustee shall establish subaccounts within the Trust for each Plan and all monies contributed to the Trust to fund the benefits to be provided by a particular Plan will be held in a separate subaccount. Unless provided otherwise in the Plan(s), such subaccounts shall be aggregate, unallocated accounts. If required by the terms of the Plan(s), contributions to a subaccount may be allocated among the Participants of the Plan(s) and such subaccount shall be divided into further subaccounts for each Participant. Such Participant subaccounts shall be bookkeeping accounts only.

ARTICLE IV.
DUTIES AND POWERS WITH RESPECT TO THE TRUST

4.1 **General Responsibility.** The general responsibilities of the Trustee shall be as follows:

- (a) The Trustee shall hold, administer, invest and reinvest, and disburse the Trust assets in accordance with the powers and subject to the restrictions stated herein.
- (b) The Trustee shall not be responsible in any way for the manner in which the Members carry out their responsibilities under this Agreement or, more generally, under the Plan(s) or JPA.
- (c) The Trustee shall disburse monies and other properties from the Trust, pursuant to the provisions of the Plan(s), to the payee or payees, and at the time or times, determined by the Trustee. The receipt of the payee shall constitute a full acquittance to the Trustee.
- (d) The Trustee may divide and redivide the Trust assets into one or more Investment Accounts.

4.2 **Exercise of Trustee's Duties.** The Trustee shall discharge its duties hereunder:

- (a) Solely in the best interest of the Participants entitled to benefits under the Plan(s);
- (b) for the exclusive purpose of providing benefits to Participants entitled to benefits under the Plan(s), and defraying reasonable expenses of administering the Trust and the Plan(s); and
- (c) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a fiduciary capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

4.3 **General Powers.** With respect to the Trust assets and subject to the limitations expressly provided in this Agreement or the JPA, the Trustee shall have the power to take the following actions:

- (a) To manage, operate, sell, contract to sell, grant options with respect to, convey, exchange, partition, transfer, abandon, improve, repair, insure, lease for any term (although commencing in the future or extending beyond the term of this Trust or Plan) and otherwise deal with all property, real or personal, in such manner, for such considerations, and on such terms and conditions as the Trustee shall decide;
- (b) To retain in cash (pending investment, reinvestment or payment of benefits) any reasonable portion of the Trust assets and to deposit cash in any depository selected by it, including those affiliated with the Trustee, notwithstanding the Trustee's or other entity's receipt of "float" from such uninvested cash;
- (c) To compromise, contest, arbitrate, settle or abandon claims and demands (exclusive of claims and demands arising under the Trust);
- (d) To begin, maintain or defend any litigation necessary in connection with the investment, reinvestment or administration of the Trust;

- (e) To have and exercise the rights of an individual owner, including the power to give proxies, to vote stocks, to join in or oppose (alone or jointly with others) voting trusts, mergers, consolidations, foreclosures, reorganizations, recapitalizations or liquidations, and to exercise or sell stock subscription or conversion rights;
- (f) To make, execute and deliver any and all documents, agreements or other instruments in writing as is necessary or desirable for the accomplishment of any of the powers and duties in this Agreement;
- (g) To hold securities or other property, including, but not limited to, variable group funding agreements or annuity contracts, in the name of the Trustee or its nominee, or nominees, or in such other form as it determines best, with or without disclosing the trust relationship, provided the records of the Trustee shall indicate the actual ownership of such securities or other property;
- (h) To appoint domestic agents, sub-trustees, sub-custodians or depositories (including affiliates of the Trustee) as to part or all of the Trust, except that the indicia of ownership of any asset of the Trust shall not be held outside the jurisdiction of the District Courts of the United States;
- (i) To retain any funds or property subject to any dispute without liability for the payment of interest, and to decline to make payment or delivery thereof until final adjudication is made by a court of competent jurisdiction;
- (j) To pay any tax, charge or assessment attributable to any benefit which, in the Member's opinion, it shall or may be required to pay out of such benefit; and to require before making any payment such release or other document from any taxing authority and such indemnity from the intended payee as the Members shall deem necessary for its protection;
- (k) To collect income payable to and dividends or other distributions due to the Trust and sign on behalf of the Plan(s) any declarations, affidavits, and certificates of ownership required to collect income and principal payments, and any required governmental filings;
- (l) To employ agents, attorneys, investment counsel, accountants or other persons (who also may be employed by or represent the Members and/or the Trustee) for such purposes as the Members considers desirable and appropriate;
- (m) To furnish the Members with such information in the Trustee's possession as those entities may need for tax or other purposes; and
- (n) To perform any and all other acts in the judgment of the Trustee necessary or appropriate for the proper management, investment and distribution of the Trust assets.

4.4 **Investments.** Except as otherwise provided herein or Article V, the Trustee shall have sole responsibility for the investment and reinvestment of the assets of the Trust. The Trustee shall diversify the investments of the Trust so as to minimize the risk of large losses, unless under the circumstances they are clearly prudent not to do so. No investment shall be made which would involve a prohibited transaction under the applicable law. The Trustee shall comply with the applicable laws of the State of Minnesota proscribing or limiting the investment of trust funds by corporate or individual trustees in or to certain kinds, types, or classes of investments or limiting the value or proportion of the trust assets that may be invested in any one property or kind,

type, or class of investment and shall comply with applicable laws proscribing or limiting the investment of public funds. Investments and reinvestments shall be subject to the above standard, and without limiting the generality of the foregoing, shall also be subject to the following:

- (a) The Trustee may, if allowed by applicable state law, invest and reinvest principal and income of the Trust in savings accounts or savings certificates, short term investments (including commingled short term investment funds) in common, preferred, and other stocks of any corporation; voting trust certificates; interests in investment trusts, including, without limiting the generality thereof, participations issued by an investment company as defined in the Investment Company Act of 1940, as from time to time amended; bonds, notes, and debentures, secured or unsecured; mortgages on real or personal property; conditional sales contracts; provided that no investment shall be made in the stocks, bonds, notes or other obligations of a Member unless there shall first have been obtained an opinion of counsel for the Member, or a ruling from the Internal Revenue Service that such investment will not jeopardize the tax exempt status of the Trust.
- (b) The Trustee may, if allowed by applicable state law, invest and reinvest principal and income of the Trust through any common or collective trust fund or pooled investment fund maintained by the Trustee for the collective investment of funds held by it in a fiduciary capacity. The provisions of the document governing any such common or collective trust fund as it may be amended from time to time shall govern any investment therein and are hereby made a part of this Trust.
- (c) The Trustee may establish and carry out a funding policy consistent with the purposes of the Plan(s) and the requirements of applicable law. Any such funding policy may be changed by the Trustee as appropriate. Any such funding policy shall require the assets of the Trust to be invested in such a manner that provides sufficient cash assets to be necessary to meet the liquidity requirements for the administration of the Plan(s). The investment and reinvestment of the principal and income of the Trust shall be subject to the funding policy. The Members shall, upon request, provide the Trustee with written notice of the Plan's cash flow history, liquidity needs, short-term financial needs, long-term financial needs, expected levels of contributions, expected levels of withdrawal, and other significant information concerning the Members which could affect the Plan's cash flow or the Trustee's exercise of investment discretion (including but not limited to the Member's ability to provide future funding).

4.5 **Participant Directed Investments.** If provided by a Plan, the Participants shall be responsible for directing the investment of the portion of the Trust assets reflecting the balances of any subaccount established for such Participant pursuant to Section 3.4. The following requirements apply to Participant directed investments:

- (a) The Trustee, or an investment advisor designated by the Trustee, shall select the list of available investments taking into consideration the characteristics of the Plan(s) and persons covered under the Plan(s).
 - (b) The Trustee (or its designee) shall establish direction procedures based upon the types of investments available. Such procedures shall include instructions regarding making and changing investments and allocations of the subaccounts assets among investments.
 - (c) The earnings/losses of the Participant directed investments shall be allocated only to the particular Participant subaccount.
- 4.6 **Compensation and Expenses.** The Trustee shall not be entitled to compensation for its services hereunder. Any expenses incurred by the Trustee in connection with the Trust held hereunder (including expenses and fees of persons employed by them pursuant to Section 4.3(l) or otherwise hereunder) shall be paid from the Trust, unless otherwise paid by the Members.
- 4.7 **Records and Accounts.** The Trustee shall maintain accurate and detailed records and accounts of all investments, receipts, disbursements and other transactions hereunder. Such records shall be available at all reasonable times for inspection by any person designated by the Member. The Trustee shall, at the direction of the Member, submit such statements, reports or other information as the Member may reasonably require.
- 4.8 **Annual Report.** As soon as practicable following the close of each fiscal year of the Trust and following the effective date of the removal or resignation of any Trustee, the Trustee shall file with the Members a written report (unless the report is waived by the Members) setting forth assets titled to the Trust.
- 4.9 **Approval of Reports.** Upon the receipt by the Trustee of the Members' written approval of any such written account or report, or upon the lapse of ninety (90) days after the Members' receipt of each written account or report, said written account or report shall be deemed to be approved by it except as to matters, if any, covered by written objections theretofore delivered to the Trustee by the Members regarding which the Trustee has not given an explanation or made adjustments satisfactory to it. The Trustee, to the extent permitted by law, shall be released and discharged as to all items, matters, and things set forth in such written account or report other than the matters covered in such written objections as provided herein. The Trustee, nevertheless, shall have the right to have its accounts approved by judicial proceedings if they so elect, in which event the Trustee and the Members shall be the only necessary parties. Further, in the event that the Members duly deliver to the Trustee written objections to any matters set forth in any such written account or report and said objections are not explained or adjusted to the satisfaction of the Members, each shall likewise have the right to have the Trustee's accounts reviewed by judicial proceedings if they so elect, in which event the Trustee and the Members shall be the only necessary parties.
- 4.10 **Indemnity.** The right of the Trustee to indemnity by the Members, if any, shall be as provided in the JPA.

**ARTICLE V.
INVESTMENT ADVISOR**

- 5.1 **Appointment of Investment Advisor.** The Trustee shall have the right to appoint one or more Investment Advisors. Nothing in this Article or Agreement requires the use of an Investment Advisor(s). All appointments of Investment Advisors shall be by written agreement between the Trustee and the Investment Advisor.
- 5.2 **Investment Advisor Agreements.** Among other matters, each agreement between the Trustee and an Investment Advisor shall provide that:
- (a) All investment directions given by the Investment Advisor to the Trustee shall be in writing and be signed by an officer or partner of the Investment Advisor or by such other person as may be designated in the agreement.
 - (b) All settlement of purchases and sales are to be in such place as the Trustee and Investment Advisors may agree.
 - (c) Payment of the cost of the acquisition, sale or exchange of any security or other property for an Investment Account shall be charged to that Investment Account.
 - (d) The responsibility of the Investment Advisor to vote proxies shall be recognized unless the agreement expressly precludes the Investment Advisor from voting proxies.
 - (e) The Investment Advisor acknowledges that it is a "fiduciary" of the Plan(s) and that for the term of the agreement it will qualify as an Investment Advisor.
- 5.3 **Investment Advisor's Authority.** Upon appointment of an Investment Advisor, the Trustee shall allocate the designated part of the Trust assets to the Investment Account of such Investment Advisor. So long as the appointment of an Investment Advisor is in effect, the Trustee shall follow the directions of the Investment Advisor with respect to its Investment Account in exercising the powers granted to the Trustee regarding investment of the Trust assets. One of those powers is voting proxies; however, the Investment Advisor will not have that power if the agreement described in Section 5.2 expressly precludes the Investment Advisor from voting proxies (and the Trustee shall have the power).
- 5.4 **Investment Advisor's Access to Records.** The Trustee shall make available to an Investment Advisor copies of or extracts from such portions of its accounts, books or records relating to the Investment Account under such Investment Advisor's control as the Trustee may deem necessary or appropriate in connection with the exercise of the Investment Advisor's functions.

**ARTICLE VI.
CHANGES IN TRUSTEE**

- 6.1 **Resignation, Removal, and Appointment of Successor Trustee.** Changes in the Trustee, such as the resignation and removal of a member of the Board of Trustees and the appointment of a successor for such individual, shall occur in accordance with the JPA.

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JOINT POWERS AGREEMENT

Effective March 31, 2011

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INTRODUCTION

This Agreement, made by and among the City of Duluth, the Duluth Airport Authority, the Duluth Entertainment and Convention Center, and the Duluth Housing and Redevelopment Authority (collectively referred to as "Members") is effective as of March 31, 2011.

WHEREAS, Section 471.59 of the Minnesota Statutes provides that two or more "governmental units" may, by agreement, jointly or cooperatively exercise any power common to them; and

WHEREAS, the Members are "governmental units" for purposes of Section 471.59 of the Minnesota Statutes; and

WHEREAS, Section 471.617 of the Minnesota Statutes provides that certain governmental entities who together employ more than 100 employees may jointly self-insure employee health benefits; and

WHEREAS, the City of Duluth employs more than 100 employees and, as a result, together the Members employ more than 100 employees; and

WHEREAS, the Members have jointly established in full force and effect certain self-insurance arrangements to provide certain employee health benefits, including medical and dental benefits, and those arrangements constitute a self-insurance pool under Minnesota law, Including Section 471.617 of the Minnesota Statutes and Chapter 2785 of the Minnesota Rules; and

WHEREAS, the Members may, in the future, wish to jointly provide other employee benefits, permitted under applicable law, to their employees; and

WHEREAS, Section 471.6175 of the Minnesota Statutes authorizes a "political subdivision or other public entity" to establish a trust to pay postemployment benefits to their employees; and

WHEREAS, the Members authorize the Board to act as a joint board for the purpose of exercising certain powers as set forth in this Agreement.

Now, therefore, each Member in exchange for the mutual covenants, promises and obligations contained herein, promises and agrees as follows:

**ARTICLE I.
ESTABLISHMENT AND PURPOSE OF THE
JOINT SELF-INSURANCE POOL**

- 1.01** The Members effectively established a joint enterprise (the "Joint Powers Enterprise"), including a joint self-insurance pool known as the Duluth Joint Insurance Pool (the "Pool"). The Joint Powers Enterprise and the Pool have operated since approximately 1981 as further described in Section 19.08.
- 1.02** The purpose of the Joint Powers Enterprise is to cooperatively maintain and administer the Plan(s).
- 1.03** The purpose of the Pool is to provide for the reciprocal assumption of risk among the Members with respect to the provision of health benefits to each Member's eligible current and former employees and their qualified dependents, as determined under the applicable Plan(s).
- 1.04** This document is intended to constitute a joint powers agreement, as required by subdivision 1 of Section 471.59 of the Minnesota Statutes.
- 1.05** This document, combined with the Bylaws, is intended to satisfy the requirements of Section 471.617 of the Minnesota Statutes and Section 2785.0400 of the Minnesota Rules.
- 1.06** It is the Members' intent to comply with applicable legal requirements pertaining to joint self-insurance pools, joint powers arrangements, and with all other applicable state and federal laws.
- 1.07** Unless specifically designated otherwise, references to any state or federal statute or regulations, including Minnesota Rules, shall include any amendments thereto.

**ARTICLE II.
DEFINITIONS**

In addition to the terms defined elsewhere in the Agreement, each of the following terms shall have the meaning set forth below:

- 2.01 AGREEMENT** – This Joint Powers Agreement, as may be amended from time to time.
- 2.02 BENEFICIARY** – A person designated by a Participant, or by the terms of a Plan, who is or may become entitled to a benefit under that Plan.
- 2.03 BOARD (BOARD OF TRUSTEES)** – The Board (also known as the Board of Trustees) is the governing body of the Joint Powers Enterprise and the Pool, established pursuant to Article III of the Agreement. The Board acts as a joint board authorized to exercise certain powers of the Members, as permitted by Section 471.59, subd. 2, of the Minnesota Statutes and as set forth in this Agreement.
- 2.04 BYLAWS** – A separate document, adopted by the Members, describing the purpose, governance, and administration of Joint Powers Enterprise.
- 2.05 CHAIRPERSON** – Representative who serves as the Chairperson of the Board having been appointed by the Member with the largest number of lives covered through the Pool.
- 2.06 FINANCIAL ADMINISTRATOR** – The person(s) or entity(ies) appointed pursuant to Section 3.03(b) who shall perform those duties set forth in Article VI.

- 2.07 FISCAL YEAR** – The twelve (12) month period, commencing on each January 1, on which the Joint Powers Enterprise's books and records are maintained.
- 2.08 INCLUDING** – Including, but not limited to.
- 2.09 INVESTMENT POLICY** – The policy established by the Board in compliance with the provisions of Section 2785.1500 of the Minnesota Rules and Section 118A.04 of the Minnesota Statutes governing investment of the assets of the Trust.
- 2.10 JOINT POWERS ENTERPRISE** – The enterprise jointly created by the Members and reflected in this Agreement.
- 2.11 MEMBERS** – Unless one or more of them have ceased to be Member pursuant to Article XVI or Article XVII, the City of Duluth, the Duluth Airport Authority, the Duluth Entertainment and Convention Center, and the Duluth Housing and Redevelopment Authority, and any other governmental entity, permitted by law, who subsequently becomes a Member under Article XX.
- 2.12 MINNESOTA RULES** – The administrative rules adopted by an agency of the State of Minnesota, including Chapter 2785 of the Minnesota Rules.
- 2.13 OPEB TRUST** – A trust established and funded pursuant to Article VII for the purpose of accumulating funds to pay "other postemployment benefits" (as that term is defined in Statement No. 45 of the Governmental Accounting Standards Board (GASB)). Such an OPEB Trust is separate from, and not part of, the Pool and Trust.
- 2.14 PARTICIPANT** – Any employee or former employee of a Member, or eligible Beneficiary, who is or may become eligible to receive a benefit of any type from a Plan.
- 2.15 PLAN(S)** – One or more benefit plans (1) jointly sponsored and maintained by the Members, pursuant to the provisions of this Agreement, (2) authorized by Minnesota law and able to be provided jointly by Minnesota governmental entities, and (3) that provide benefits for a Member's employees, former employees, including retirees, and persons covered through them (e.g., dependents) in accordance with the terms and conditions of such benefit plan(s), including eligibility. The Plans are identified in Appendix B. A Plan may be part of the Pool.
- 2.16 POOL** – The joint self-insurance pool created by the Members under Minnesota law, known as the Duluth Joint Insurance Pool, through which certain Plans are funded and operated. The Pool is a collective group of Members in a given Plan. Absent an agreement expressly to the contrary, a separate Pool shall exist for each such Plan and a separate contract shall exist between the Service Company and the Pool for the rendering of services or benefits for which such Pool is formed.
- 2.17 QUORUM** – A quorum is the required percentage of possible Representatives necessary for the Board to hold a meeting and conduct business, including Pool business. A Quorum is present when a majority (more than fifty (50%) percent) of the Representatives are physically present at a duly called meeting.
- 2.18 REPRESENTATIVE** – Each Member's designated individual to serve and act on behalf of the Member on the Board. The Representative shall be the chief administrative officer, or a person with comparable responsibilities, skills, experience, etc., as determined by the Member.
- 2.19 RESERVES** – Amount established through an excess of contributions over expenses and established to pay run-off claims and/or reduce the volatility of claim fluctuations.

- 2.20 SERVICE COMPANY** – The person(s) or entity(ies) appointed pursuant to Section 3.03(b) who shall: (1) be the principal manager of the Pool, (2) supervise and control the day to day operations of the Pool, (3) carry out the purpose of the Pool as directed by this Agreement and as may be directed from time to time by the Board, and (4) perform those duties set forth in Article VI.
- 2.21 TRUST** – A trust established and funded pursuant to Article VII for the purposes of: (1) paying the administrative expenses of, and the benefits provided under, the Plan(s); (2) purchasing stop loss insurance; and (3) paying any other expenditures authorized by the terms of this Agreement.

**ARTICLE III.
MEMBERSHIP, AUTHORITY, AND DUTIES OF THE BOARD**

- 3.01** The Joint Powers Enterprise shall be managed by the Board pursuant to the terms of this Agreement. The Board shall consist of one Representative from each Member.
- 3.02** In conformance with Section 2785.0500 of the Minnesota Rules, each Member agrees that because (1) the number of seats on the Board equals the number of Members, and (2) each Member is entitled to a Representative on the Board, the Members, both individually and collectively, have effectively elected the Board. A Representative's term on the Board shall be established by the Member appointing the Representative. The Member shall notify the Board immediately upon designation of a Representative.
- 3.03** The Board shall have the authority and duty to accomplish the purposes set forth in Article I above and, in furtherance of such authority and duty, shall:
- (a) Maximize the value of the Members' and Pool's benefit dollars;
 - (b) Select, enter into a contract with, and/ or hire one or more service providers, Including Service Companies, Financial Administrators, agents, independent contractors, attorneys, auditors, and such other persons as may be necessary to administer and accomplish the purpose(s) of the Joint Powers Enterprise; provided, however, that the Board shall not have the authority to enter into any collective bargaining agreement on behalf of the Members with employees of the Members;
 - (c) Approve the compensation for all such service providers;
 - (d) Appoint committees;
 - (e) Carry out education and other programs relating to health, accident and other claims management and reductions;
 - (f) Direct the collection and payment of funds to be used for the administration of, and the provision of benefits under, the Plan(s);
 - (g) Invest funds in accordance with the Investment Policy;
 - (h) Select one or more depositories for the funds of the Joint Powers Enterprise in compliance with the provisions of Section 2785.1500 of the Minnesota Rules;
 - (i) Cause to be purchased stop loss coverage, in compliance with applicable law, Including Section 471.617 of the Minnesota Statutes and Section 2785.1300 of the Minnesota Rules, and other types of insurance reviewed and selected by the Board;

- (j) Review and approve the annual budget of the Joint Powers Enterprise and periodic reports of the financial affairs of the Joint Powers Enterprise;
 - (k) Approve and submit to each Member annually an audited report of the financial affairs of the Pool, made by a certified public accountant within one hundred eighty (180) days from the end of each Fiscal Year in accordance with generally accepted auditing principles;
 - (l) Ensure the Pool complies with the reporting requirements contained in Section 2785.1600 of the Minnesota Rules;
 - (m) Change, amend or modify the Plan(s);
 - (n) Cause to be purchased fidelity bonds required by law or otherwise determined to be appropriate by the Board;
 - (o) Establish and recommend monthly and supplementary contributions to the Trust;
 - (p) Perform any responsibilities assigned to it under the Plan(s);
 - (q) In accordance with the provisions of Article XVI, recommend to the Members the expulsion of any individual Member from the Pool for failure to perform its obligations under this Agreement; and
 - (r) Carry out such other activities as are necessarily implied or required to carry out the purposes of the Joint Powers Enterprise specified in Article I or the specific activities enumerated in this Article III.
- 3.04** As appropriate, for the purpose of conducting day to day business of the Board, the Board may designate one or more designees to act on its behalf. Such designees may include one of the Members, a Representative, or an outside third party service vendor. Such designation shall be made by the Board in writing, including the parameters of the designation, and action taken by a designee must be on behalf of the Board, reflecting Board decisions and authority.
- 3.05** The Board may, but is not required to, appoint one or more advisory committees. The purpose of any such committee may include, without limitation, the receipt and processing of information relating to group employee benefits, and the future direction of such benefits as well as other programs and services. The Board shall consider, but is not required to adopt, advisory committee recommendations and proposals.
- 3.06** The Board, with due consideration given to recommendations submitted by any advisory committee that may be established, shall, unless otherwise expressly agreed, retain final authority in all matters relative to this Agreement.
- 3.07** No one serving on the Board shall receive any compensation or other payment for such services.

ARTICLE IV. MEETINGS OF THE BOARD

- 4.01** Regular meetings of the Board shall be held as often as necessary to carry out the purposes of the Joint Power Enterprise, but no less than four (4) meetings shall be held in each Fiscal Year.

- 4.02** Special meetings of the Board may be called by its Chairperson or by any two (2) Representatives.
- 4.03** Written notice of regular or special meetings of the Board shall be given to each Representative at least five (5), but no more than ten (10), business days prior to such meeting. An agenda specifying the subject of any special meeting shall accompany such notice. Business conducted at special meetings shall be limited to those items specified in the agenda.
- 4.04** The time, date and location of regular meetings of the Board shall be determined by the Board. The four (4) required regular meetings will be scheduled at the beginning of each Fiscal Year. Additional meetings may be set as needed.
- 4.05** Transcription of meetings shall be accomplished pursuant to a policy established by the Board in accordance with applicable law.
- 4.06** Each Member shall be entitled to one (1) vote on the Board through its Representative. No proxy votes or absentee votes shall be permitted. Voting shall be conducted in accordance with the rules of procedure established pursuant to Section 4.10 and the requirements of applicable law.
- 4.07** The Board may establish policies governing its own conduct and procedure, consistent with the Agreement.
- 4.08** Minutes of all regular, special and emergency meetings of the Board shall be sent to the Representatives of each Member.
- 4.09** All meetings of the Board shall be conducted in the manner required by applicable law, including Chapter 13D of the Minnesota Statutes. The Chairperson shall cause to be published any schedule or notice of meetings of the Board as required by law.

ARTICLE V. OFFICERS

- 5.01** Officers of the Joint Powers Enterprise shall consist of a Chairperson, Treasurer and Secretary. Each officer's responsibilities shall be described in the Bylaws. Other than the Chairperson, the Board shall elect officers for the coming Fiscal Year at the last regular meeting scheduled during the current Fiscal Year. The Secretary and Treasurer will be elected on even years and serve for two (2) consecutive years. The Board may from time to time establish other offices and may elect a Representative to serve in any of such offices. With the exception of the Chairperson, the Board may fill any vacancies which may occur in such offices for the remainder of the term. The Chairperson is appointed as described in Section 2.06.

ARTICLE VI. SERVICE COMPANY AND FINANCIAL ADMINISTRATOR

- 6.01** The Board shall contract with one or more Service Companies and one or more Financial Administrators as required by Section 2785.0800 of the Minnesota Rules.
- 6.02** The Board shall select each Service Company and Financial Administrator in the manner specified in the Bylaws, which shall be consistent with Section 471.6161, subd. 2, of the Minnesota Statutes.

- 6.03** The Board shall review the performance of each Service Company and Financial Administrator on an annual basis and shall make a request for proposal for such positions no less infrequently than every five (5) years. The Board shall review the performance of other service providers at least annually and conduct a market search for such providers on an as needed basis.
- 6.04** The compensation of the Service Company and the Financial Administrator shall be negotiated and approved by the Board and shall be payable pursuant to the contract between the Board and the Service Company or Financial Administrator.
- 6.05** Subject to the oversight of the Board, each Service Company shall be the principle operating manager of the Plan(s) and the Pool and shall supervise and control day-to-day operations of the Plan and the Pool and carry out the purposes of the Plans and the Pool as directed by the Board. The services to be provided by the Service Company shall be determined by the Board and reflected in a service agreement between the parties and shall include, at a minimum, the services identified in Section 2785.0800 of the Minnesota Rules.
- 6.06** The Service Company shall have expertise in, and be appropriately licensed to provide services for, the coverages provided through the Pool.
- 6.07** Subject to the oversight of the Board, the Financial Administrator shall invest the Trust's assets in accordance with the Investment Policy and provide other financial and/or accounting services as determined by the Board and reflected in a service agreement between the parties.

ARTICLE VII. TRUSTS

- 7.01** There shall be established a Trust (under Section 115 of the Internal Revenue Code) for the purpose of holding the assets of the Plan(s) and the Pool in accordance with Section 2785.1500 of the Minnesota Rules. Such Trust may also be used for the purpose of holding the assets of a Plan not part of the Pool. The Trusts shall be divided into sub-accounts, one for each Plan funded through the Trust. Additional subdivisions of the sub-accounts may be established and maintained at the discretion of the Board.
- 7.02** An OPEB Trust may also be established for the purpose of funding postemployment benefits under the Plan(s). For this purpose "establish" Includes assuming responsibility for any trust that may already exist.
- 7.03** Other than as a result of a proper payment or reimbursement from the OPEB Trust to the Trust, the assets of the Trust and an OPEB Trust shall not be combined. The assets of the Trust shall be used to pay benefits provided under the Plan(s) and the administrative expenses of the Plan(s) and the Pool in accordance with applicable law.
- 7.04** Contributions to the Trust shall be determined and administered in accordance with the following:
- (a) The Board shall also determine the amount necessary to establish Reserves for the given Fiscal Year for each Plan that is part of the Pool. This Reserves calculation is conducted with respect to each Fiscal Year.
 - (b) Prior to the beginning of each Fiscal Year and considering the recommendations of the Service Company or other service provider, the Board, in accordance with Article X, shall

approve (1) an expense budget for each Plan for the coming Fiscal Year, and (2) the monthly premium rates for each Plan.

- (c) A Member's contribution shall be determined based upon the established premium rates and the number of Participants enrolled in each Plan through such Member.
- (d) Members shall make monthly contributions to the Trust. Member contributions shall be allocated to the appropriate sub-account within the Trust.
- (e) Reserves are carried forward each Fiscal Year. Reserves remain unallocated and shall be available to pay benefits and administrative expenses of the applicable Plan funding through the Trust, Including the Pool, as a whole. Notwithstanding the foregoing, if allowed by Section 2785.1100 of the Minnesota Rules, the Board may declare a dividend from the Reserves as described in the Bylaws.
- (f) With respect to Articles XVI and XVII, a Member participating in the Pool shall have a calculated share of Reserves accumulated during the Member's participation in the particular Plan funded through the Trust, Including the Pool. Any new Member joining a Plan Pool must complete five (5) years of participation in the Plan before such Member is entitled to a calculated share of Reserves resulting from that Member's participation in the Plan funded through the Trust, Including the Pool.
- (g) A Member's calculated share of Reserves shall be based upon the ratio of cumulative premium payments paid into the Trust with respect to the Plan by a Member to the cumulative premium payments paid into the Trust with respect to the Plan by all Members over the applicable time frame. For example, if a Member is withdrawing effective December 31, 2011, and its cumulative premium payments while a Member account for forty-five percent (45%) of the cumulative premium payments of all Members for that same time frame, that Member's calculated share is forty-five percent (45%) of the Reserves.
- (h) Sufficient information to determine allocations of the Banked Reserves to each Member shall be maintained as part of the Trust's, Including the Pool's, financial records.
- (i) If, during any Fiscal Year, the Board determines that the funds available in any sub-account of the Trust may be insufficient to meet a Plan's current or anticipated future claims or administrative expenses, the Board may require a supplementary contribution from the Members. The total supplementary contribution shall be allocated among the Members on a pro-rata basis as determined by the Board.

7.05 The Board is responsible for the operation and administration of the OPEB responsibilities of the Plan(s), Including having the unfunded liability calculated, determining the manner in which such unfunded OPEB liability shall be handled, and determining each Member's responsibility for such unfunded liability.

7.06 Each Member is jointly and severally liable for all liabilities and expenses of the Pool, including liabilities and expenses incurred during runoff of the Pool prior to final dissolution.

7.07 The Board shall monitor the Pool's annualized premium volume. To the extent such premium volume drops below the requirements established in Section 2785.1100 of the Minnesota Rules, the Board shall take such steps to restore an adequate premium value as required by such regulation.

**ARTICLE VIII.
PLAN(S) OF BENEFITS**

- 8.01** The current Plan(s) at any time are identified in Appendix B.
- 8.02** The Board may, from time to time, amend or terminate a Plan, or adopt new or additional Plan(s).
- 8.03** Any employee or collective bargaining notification regarding the Plan(s) shall be the responsibility of the Member.
- 8.04** In accordance with Section 471.617 of the Minnesota Statutes, a Plan may be self-insured. A self-insurance Pool made available by the Board shall be a pool established and operated by the Board, or by the Board and one or more other joint powers governing boards governed by Section 471.59 of the Minnesota Statutes and Chapter 2785 of the Minnesota Rules.
- 8.05** Any Plan amendment, when approved by the Board, shall result in a re-determination, made on an actuarial basis, of the contributions due to the Trust. The Board shall determine the amount of the increased or reduced payment required in light of the amendment.
- 8.06** A Member's participation in the Plan(s), including adding and dropping participation in a Plan and the required level of participation (if any), shall be governed by the Bylaws.
- 8.07** Except as otherwise provided with respect to the run-out claims of expelled or withdrawing Members, the Members agree to aggregate claim experience and use a common premium for each Plan.

**ARTICLE IX.
STOP LOSS INSURANCE**

- 9.01** The Board will cause to be purchased stop loss insurance as required by applicable law, including Section 2785.1300 of the Minnesota Rules and Section 471.617 of the Minnesota Statutes.
- 9.02** Membership in the Joint Powers Enterprise shall not preclude any Member from purchasing any insurance coverage above those amounts purchased by the Joint Powers Enterprise. The Joint Powers Enterprise shall, when requested, provide any information needed by the Member to obtain quotes for any such insurance coverage.

**ARTICLE X.
MATTERS REQUIRING APPROVAL**

- 10.01** The Members shall act on matters requiring approval of the Members by resolution of their governing bodies. The following matters require approval of seventy-five percent (75%), rounded up if a fraction, of all Members:
- (a) Amendments to this Agreement;
 - (b) Approval of any proposed new Member(s);
 - (c) Merger of the Pool with another Pool; and

- (d) Termination of the Pool.

10.02 The Board shall act on matters requiring approval of the Board by vote of the Representatives. A Quorum shall be required to hold a Board meeting. Except as otherwise provided in this Section 10.02, the Board may act by majority (more than fifty (50%) percent) vote of the Representatives present at a Board meeting. Notwithstanding the foregoing, the following matters require approval of a majority (more than fifty (50%) percent) of all Representatives (regardless of the number present at the Board meeting):

- (a) Selection of the Service Company, Financial Administrator, and other service providers, (accountants, attorneys, etc.);
- (b) Selection of stop loss coverage and carrier(s);
- (c) Approval of annual budget of the Joint Powers Enterprise, Including the Pool;
- (d) Approval of any Plan amendments; and
- (e) Approval of the reduction or addition any Plan(s).

ARTICLE XI. OBLIGATIONS OF MEMBERS

11.01 The governmental entities have entered into this arrangement to provide, on a joint basis, the benefits described in the Plan(s). In order for the purposes of the joint powers arrangement to be realized, each Member needs to be actively engaged in the management and decision making of the Board with respect to the joint powers entity. The obligations of each Member Include the following:

- (a) To appropriate or budget for and, where necessary, to levy for, and pay promptly all monthly and supplementary or other contributions to the Trust within thirty (30) days from notice and in such amounts as are established within the scope of this Agreement;
- (b) To promptly select a Representative to serve on the Board;
- (c) To fully cooperate with the Service Company, the Financial Administrator, the Joint Powers Enterprise's attorneys and auditors and any agent, employee, officer or independent contractor of the Joint Powers Enterprise in any matter relating to the purpose and powers of the Joint Powers Enterprise, Including furnishing all reasonably necessary Participant data directly to the Board or its designee;
- (d) To review all proposed changes to a Plan prior to the Board's final vote on such changes;
- (e) To promptly notify all of the Member's Plan Participants of the withdrawal or expulsion of such Member from the Joint Powers Enterprise;
- (f) To promptly act on all matters requiring approval of the Member's governing body and to not withhold such approval unreasonably or arbitrarily; and
- (g) To take such other actions as may be required by the Bylaws.

11.02 The joint powers entity is not capable or otherwise authorized to act on behalf of a Member with respect to each Members' collective bargaining obligations. Each Member shall be solely responsible for the collective bargaining of benefits to the full extent required by applicable law, and for providing any notices regarding collectively bargained benefits, Including the obligation to notify certain union officials regarding the adoption of a self-insured health benefit plan set forth in Section 471.617, subd. 4, of the Minnesota Statutes.

11.03 At the discretion of the Board, non-performance of Member obligations, whether in whole or in part, may be the basis for a recommendation to expel pursuant to Article XVI.

ARTICLE XII. LIABILITY OF MEMBERS

12.01 Unless specifically provided otherwise in this Agreement, a Member is not liable for the acts or omissions of another Member.

ARTICLE XIII. LIABILITY OF REPRESENTATIVES

13.01 The Representatives shall discharge their duties solely in the interest of the Plan participants entitled to benefits under any Plan, and:

- (a) For the exclusive purpose of:
 - 1) providing benefits to Participants entitled to benefits under the Plan(s); and
 - 2) defraying reasonable expense of administering the Plan(s) and Trust, Including the Pool.
- (b) With the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.
- (c) In accordance with the documents and instruments governing the Plan(s) and Trust, Including the Pool, insofar as such documents and instruments are consistent with the law.

13.02 To the fullest extent permitted by applicable law, the Representatives shall not be liable for any mistake in judgment or other action made, taken or omitted by them in good faith; nor for any action made, taken or omitted by any agent, employee or independent contractor selected with reasonable care, nor for loss incurred through investment of Joint Powers Enterprise funds, or failure to invest. No Representative shall be liable for any action taken or omitted by any other Representative. No Representative shall be required to give a bond or other security to guarantee the faithful performance of his/her duties hereunder except as required by this Agreement or by law. The assets of the Trust shall be used to defend and hold harmless any Representative for actions taken by the Board if performed by the Representative within the scope of his authority. The Joint Powers Enterprise shall purchase insurance providing fiduciary liability coverage for Representatives.

**ARTICLE XIV.
STANDARDS OF FINANCIAL INTEGRITY AND LOSS EXPERIENCE**

- 14.01** The Board shall established standards of financial integrity and loss experience applicable to participation in the Joint Powers Enterprise (Including the Pool), which shall be described in the Bylaws.

**ARTICLE XV.
CONTRACTUAL OBLIGATION**

- 15.01** The obligations and responsibilities of the Members set forth in this Agreement, including the obligation to take no action inconsistent with this Agreement, as originally written or validly amended, shall remain a continuing obligation and responsibility of each Member. This Agreement may be enforced in law or equity either by the Joint Powers Enterprise itself or by any Member. The consideration for the duties imposed upon the Members by this Agreement is based upon the mutual promises and agreements of the Members set forth herein and the advantages gained by the Members through reduced administrative costs for the processing of employee benefits. Except to the extent of the limited financial contributions to the Joint Powers Enterprise each Member has agreed to make, no Member agrees by this Agreement to be responsible for any claims of any kind against any other Member. The Members intend in the creation of the Joint Powers Enterprise to establish an organization for joint administration of employee benefits within the scope set forth in this Agreement only and do not intend to create between the Members any relationship of partnership, surety, indemnification or liability for the debts of or claims against another.

**ARTICLE XVI.
EXPULSION OF A MEMBER**

- 16.01** The Board shall, on at least an annual basis, compare the status and experience of each Member with the Joint Powers Enterprise's criteria for expulsion as described in the Bylaws.
- 16.02** Following reasonable efforts to informally resolve a situation, a Member may be expelled from the Joint Powers Enterprise for failing to perform or fulfill the responsibilities assigned to Members under the Agreement or for any other action or failure to act determined by the Board to be detrimental to the interests of the Joint Powers Enterprise, including the Member's failure to satisfy the standards of financial integrity and loss experience described in Article XIII.
- 16.03** The expulsion of a Member must be approved by a unanimous vote of all Members, excluding the Member whose expulsion is being voted upon, as evidenced by resolution of the governing body of each Member. Following reasonable attempts by the Board to resolve the situation, the expulsion proceedings set out below shall be followed.
- 16.04** No Member may be expelled except after written notice from the Board of the reason for the expulsion and after a reasonable opportunity of not less than fifteen (15) days to cure. Within such fifteen (15) day period, the Member may request a hearing before the Board prior to any decision being made as to whether to recommend expulsion. The Board shall set the date for such hearing, which shall not be less than fifteen (15) days after expiration of the time period for correction. The Board may appoint a hearing officer to conduct such hearing and make recommendations to the Board based upon findings of the fact; provided, however, if the hearing is conducted by a hearing officer, the Member may request a further hearing before the full Board. Such request shall be in writing and addressed to the Chairperson. The Board or hearing

officer may recommend a decision at the close of the hearing or within fifteen (15) days thereafter. The expulsion of a Member, following the notice and hearing as set forth in this Section, shall be final when approved as specified in Section 16.01 and shall become effective thirty (30) days following such approval, unless a different effective date is agreed to by the Board and the expelled Member. At such a hearing, the appealing Member may not vote or be the hearing officer.

- 16.05** After expulsion, the former Member shall continue to be fully liable for (a) any payment due to the Trust with respect to the period prior to the date of expulsion, (b) any other unfulfilled obligation arising at any time attributable to the period prior to the date of expulsion, and (c) any other unfulfilled obligation as if it was still a Member of the Joint Powers Enterprise.
- 16.06** The Joint Powers Enterprise shall have no obligation with respect to expenses incurred under a Plan by a Participant or Beneficiary covered through an expelled Member after the effective date of such expulsion. No claim under a Plan by a Participant or Beneficiary covered through an expelled Member for an expense that was incurred before the effective date of expulsion shall be paid if not presented to the Plan, or its designated agent, within one hundred twenty (120) days after the effective date of expulsion (i.e., any such claim will not be paid by the Plan). Except as provided below, the obligation of the Joint Powers Enterprise to administer claims for expenses incurred under a Plan by a Participant or Beneficiary covered through an expelled Member prior to the effective date of expulsion ("run-out claims") shall continue for such claims as may have been filed or which are filed within one hundred twenty (120) days after the effective date of the expulsion of the Member. Payment and administration of any claims for expenses incurred prior to the effective date of a Member's expulsion that are submitted for payment after such one hundred twenty (120) day period shall be the sole responsibility of the expelled Member.
- 16.07** The expelled Member shall deposit in each sub-account within the Trust three (3) months of the current premium (the "withdrawal fee"). Such payment shall be made on or before the effective date of the expulsion. If the expelled Member fails to make such payment in a timely manner, the Joint Powers Enterprise's obligation to administer and pay run-out claims shall be extinguished and the expelled Member shall be solely liable and responsible for paying and administering such claims. Notwithstanding anything herein to the contrary, the withdrawal fee shall be used solely to pay run-out claims and any administrative expenses incurred with respect to paying such claims. If the expelled Member's withdrawal fee with respect to a Plan is exhausted before all run-off claims are paid under the Plan, the expelled Member shall deposit in the appropriate sub-account within the Trust a sufficient amount to fund all subsequent run-out claims prior to the payment of any such claims. No later than the latter of (1) Board approval of the Fiscal Year audit, or (2) sixty (60) days after payment of the last run-out claim of expelled Member, any remaining portion of the withdrawal fee shall be repaid to the expelled Member.
- 16.08** Following the close of the Fiscal Year including the effective date of the Member's expulsion, allocation of the accumulated Reserves shall be made as provided in Section 7.04(f) and (g).
- (a) If the expelled Member's calculated share of accumulated Reserves for a Plan is positive, the expelled Member shall be paid such amount in three (3) equal annual installments beginning with the first Fiscal Year in which the allocation of net surplus or deficit is made.
 - (b) If the expelled Member's calculated share of accumulated Reserves for a Plan is negative, the expelled Member shall be liable to the Joint Powers Enterprise for such amount. This amount must be paid to the Joint Powers Enterprise within ninety (90) days of demand by the Joint Powers Enterprise.

**ARTICLE XVII.
VOLUNTARY WITHDRAWAL FROM THE JOINT POWERS ENTERPRISE**

- 17.01** After the initial five (5) year commitment, a Member may withdraw effective as of the close of any Fiscal Year upon one hundred eighty (180) days advance written notice to the Joint Powers Enterprise or by such other lesser advance notice of not less than thirty (30) days deemed reasonable by the Board in its sole discretion. Upon the Board's receipt of a notice of withdrawal, the withdrawal of such Member is irrevocable unless such revocation is allowed at the sole discretion of the Board. Upon a Member's submission of a notice of withdrawal, such Member forfeits all of its voting rights in its own right and as a Representative on the Board, unless allowed to vote on any particular matter at the sole discretion of the Board. The rights and duties of the Joint Powers Enterprise with respect to a withdrawing Member in the Joint Powers Enterprise shall be as set forth below.
- 17.02** After voluntary withdrawal, the former Member shall continue to be fully liable for (a) any contribution due to the Trust, Including the Pool, with respect to the period prior to the date of withdrawal, (b) any other unfulfilled obligation arising at any time attributable to the period prior to the date of withdrawal, and (c) any other unfulfilled obligation as if it was still a Member of the Joint Powers Enterprise.
- 17.03** The Joint Powers Enterprise shall have no obligation with respect to claims incurred under a Plan by a Participant or Beneficiary covered through a withdrawing Member after the effective date of such withdrawal. No claim under a Plan by a Participant or Beneficiary covered through a withdrawing Member that was incurred before the effective date of voluntary withdrawal shall be paid if not presented to the Plan, or its designated agent, within one hundred twenty (120) days after the effective date of the voluntary withdrawal (i.e., any such claim will not be paid by the Plan). Except as provided below, the obligation of the Joint Powers Enterprise to administer claims incurred under the Plan by a Participant or Beneficiary covered through a withdrawing Member prior to the effective date of withdrawal ("run-out claims") shall continue for such claims as may have been filed or which are filed within one hundred twenty (120) days after the effective date of the voluntary withdrawal of the Member. Payment and administration of any claims for expenses incurred prior to the effective date of a Member's voluntary withdrawal that are submitted for payment after such one hundred twenty (120) day period shall be the sole responsibility of the withdrawing Member.
- 17.04** The withdrawing Member shall deposit in each sub-account within the Trust three (3) months of the current premium (the "withdrawal fee"). Such payment shall be made on or before the effective date of the withdrawal. If the withdrawing Member fails to make such payment in a timely manner, the Joint Powers Enterprise's obligation to administer and pay run-out claims shall be extinguished and the withdrawing Member shall be solely liable and responsible for paying and administering such claims. Notwithstanding anything herein to the contrary, the withdrawal fee shall be used solely to pay run-out claims and any administrative expenses incurred with respect to paying such claims. If the withdrawing Member's withdrawal fee with respect to a Plan is exhausted before all run-off claims are paid under the Plan, the withdrawing Member shall deposit in the appropriate sub-account within the Trust a sufficient amount to fund all subsequent run-out claims prior to the payment of any such claims. No later than the latter of (1) Board approval of the Fiscal Year audit, or (2) sixty (60) days after payment of the last run-out claim of withdrawing Member, any portion of the withdrawal fee remaining shall be repaid to the withdrawing Member.
- 17.05** Following the close of the Fiscal Year including the effective date of the Member's withdrawal, allocation of the accumulated Reserves shall be made as provided in Section 7.04(f) and (g).

- (a) If the withdrawing Member's calculated share of accumulated Reserves for a Plan is positive, the withdrawing Member shall be paid such amount in three (3) equal annual installments beginning with the first Fiscal Year beginning in the Fiscal Year in which the allocation of net surplus or deficit is made.
- (b) If the withdrawing Member's calculated share of accumulated Reserves for a Plan is negative, the withdrawing Member shall be liable to the Joint Powers Enterprise for such amount. This amount must be paid to the Joint Powers Enterprise within ninety (90) days of demand by the Joint Powers Enterprise.

ARTICLE XVIII. DURATION AND DISSOLUTION

- 18.01** Pursuant to Section 471.59, subd. 4, of the Minnesota Statutes, but subject to the provisions herein relating to Member withdrawal, this Agreement shall be ongoing.
- 18.02** To the extent not prohibited by applicable law, the Plan(s) and/or Trust, Including the Pool, may merge with any other plan, trust, or pool established under Minnesota law upon a vote of Members described in Article X.
- 18.03** Coverage under the Plan(s) shall cease to be provided through the Pool upon the occurrence of any one of the following events:
- (a) Revocation of the Pool's authority to self-insure by the Minnesota Commissioner of Commerce; or
 - (b) A vote of Members described in Article X made in accordance with Section 2785.0700 of the Minnesota Rules.

No Member may withdraw or be expelled from the Pool after revocation of the Pool's authority to self-insure or after the Pool notifies the Minnesota Commissioner of Commerce of its intent to cease providing coverage under the Plans.

- 18.04** Upon ceasing to provide coverage through the Plans in accordance with Section 18.03, the Trust, Including the Pool, shall continue to exist as a runoff pool as required under Section 2785.0700 of the Minnesota Rules.
- 18.05** Following ceasing to provide coverage through the Plans in accordance with Section 18.03, the Trust, Including the Pool, may dissolve upon authorization of the Minnesota Commissioner of Commerce in accordance with Section 2785.0700 of the Minnesota Rules. To the extent not precluded by applicable law, upon dissolution of the Trust, Including the Pool, the rights and duties of the Joint Powers Enterprise to each Member and the rights and duties of each Member to the Joint Powers Enterprise shall be the same as those with respect to a withdrawing Member as outlined in Article XVII.

ARTICLE XIX. MISCELLANEOUS

- 19.01 Notice** – Any notice required by this Agreement shall be in writing and shall be deemed to have been given when deposited in a United States Post Office, registered or certified mail, postage prepaid, return receipt requested and addressed as follows:

- (a) If to the Joint Powers Enterprise: at the business address of the then current Chairperson of the Board.
- (b) If to a Member: to the address set forth on Appendix A or to such other address as any party to this Agreement may from time to time specify in writing to the other parties and to the Joint Powers Enterprise.

Any notice required by this Agreement may be waived by the party(ies) to whom such notice is required to be provided hereunder.

19.02 Section Headings – The section headings inserted in this Agreement are for convenience only and are not intended to and shall be construed to limit, enlarge or affect the scope or intent of this Agreement or the meaning of any provision hereof.

19.03 Validity and Savings Clause – In the event any provision of this Agreement shall be declared by a final judgment of a Court of competent jurisdiction to be unlawful or unconstitutional or invalid as applied to any Member, the lawfulness, constitutionality or validity of the remainder of this Agreement shall not be deemed affected thereby.

19.04 Counterparts – This Agreement and any amendments thereto may be executed in any number of counterparts which taken together constitute a single instrument.

19.05 Amendment – The Members may, in accordance with Section 10.01, amend this Agreement and such amendment shall be evidenced by a writing executed by the Members.

19.06 Minnesota Law. This Agreement shall governed by, and the Joint Powers Enterprise (Including the Plan(s), Pool, and Trusts) shall be operated in accordance with, Minnesota law, Including Chapters 13, 13D, and 471 of the Minnesota Statutes.

19.07 Other Applicable Law. The Plan(s), Pool, and Trusts shall be operated in accordance with applicable federal law, Including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Consolidation Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as it applies through the Public Health Services Act ("PHSA").

19.08 Pre-2010. The City of Duluth, an original Member of this Agreement, together with other governmental entities has maintained the Group Health Fund for many years, relating as far back to approximately 1981. Changes have been made over the years, Including what governmental entities participated, the number of benefit menu options, the content of the menu of benefits, etc. However, the Group Health Fund has stayed substantially the same. It is the intent of this Agreement to appropriately reflect the existence of the Group Health Fund for purposes of compliance with applicable law, Including Section 417.61 of the Minnesota Statutes and Chapter 2785 of the Minnesota Rules.

19.09 Entire Agreement - All the agreements, covenants, representations, and warranties among the Members expressed or implied, oral or written, concerning the subject matter of this Agreement are contained in this Agreement. All prior and contemporaneous conversations, negotiations, agreements, representations, covenants and warranties, concerning the subject matter of this Agreement, are merged into this Agreement. Union contracts, negotiations, etc. are expressly outside the matter of this Agreement, are not merged into this Agreement, and remain the sole responsibility of each Member, not the Joint Powers Enterprise.

**ARTICLE XX.
NEW MEMBERS**

20.01 The Joint Powers Enterprise may consider applications from potential additional members under the following conditions and any additional conditions contained in the Bylaws:

- (a) A formal application for consideration must be submitted by the potential member.
- (b) An application fee may be required after an introductory meeting reviewing the program. This fee is non-refundable and is for the purpose of obtaining stop loss quotes, attending meetings, preparing individualized financial projections, and other administrative matters associate with the consideration of the prospective member's application.
- (c) An additional fee may be required should the prospective member actually become a Member. This fee is for the cost of enrolling and entering the Member's Participants and Beneficiaries into each Service Company's "system", benefit booklets, identification cards, introductory meetings and any necessary amendments.
- (d) The new Member must agree to an Initial five (5) year commitment, subject to the continuation of the Trust, Including the Pool.

20.02 Addition of a new Member must be made on a vote of the Members as described in Section 10.01.

20.03 Approved new Members normally enter the program on January 1 (i.e., the beginning of the Fiscal Year). The Board may allow entry at other times and may impose restrictions, limitations, etc. with respect to such entry.

IN WITNESS WHEREOF, the Members have caused this Agreement to be executed by their duly authorized officers and their undersigned representatives as of the date above written.

CITY OF DULUTH

DULUTH AIRPORT AUTHORITY

By: _____

By: _____

Title

Title

Date

Date

**DULUTH ENTERTAINMENT AND
CONVENTION CENTER**

By: _____

Title

Date

**DULUTH HOUSING AND REDEVELOPMENT
AUTHORITY**

By: _____

Title

Date

APPENDIX A
Members

City of Duluth
411 W. 1st St. Rm 402
Duluth MN 55802

Duluth Airport Authority
4701 Grinden Dr.
Duluth MN 55811

Housing & Redevelopment Authority of Duluth
222 E 2nd St.
PO Box 16900
Duluth, MN 55816-0900

Duluth Entertainment and Convention Center
350 Harbor Drive
Duluth MN 55802

APPENDIX B
Plans

Medical Plan – see attached copy of the Plan Document and Summary Description

Dental Plan – see attached copy of the Plan Document and Summary Description



Summary Plan Description

*City of Duluth Medical Benefit Plan
NationalONESM Plan*

Notice of Grandfathered Medical Plan

Your employer believes this medical plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your employer. If you are on a plan subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or **dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at **healthreform.gov**.

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Summary Plan Description Effective Date: The later of January 1, 2011 and the Covered Person's effective date of coverage under the Plan.

HealthPartners NationalONESM Plan

Schedule of Payments

See Sections III. and IV. of this SPD for additional information about covered services and limitations.

The amount that the Plan pays for covered services is listed below. The Covered Person is responsible for the specified dollar amount and/or percentage of charges that the Plan does not pay.

Coverage may vary according to your network or provider selection.

These definitions apply to the Schedule of Payments. They also apply to the SPD.

Charge:

For covered services delivered by participating network providers, this is the provider's discounted charge for a given medical/surgical service, procedure or item.

For covered services delivered by out-of-network providers, this is the provider's charge for a given medical/surgical service, procedure or item, according to the usual and customary charge allowed amount.

The usual and customary charge is the maximum amount allowed which the Plan considers in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same region.

A charge is incurred for covered ambulatory medical and surgical services on the date the service or item is provided. A charge is incurred for covered inpatient services on the date of admission to a hospital. To be covered, a charge must be incurred on or after the Covered Person's effective date and on or before the termination date.

Combined Day Limit:

Your total benefit is combined for inpatient hospitalization, skilled nursing facility care services and inpatient behavioral health services, and limited to 365 days per period of confinement. Each day of such services provided under the Network Benefits and Out-of-Network Benefits counts toward this combined day limit, for the same period of confinement.

Copayment/Coinsurance:

The specified dollar amount, or percentage, of charges incurred for covered services, which the Plan does not pay, but which a Covered Person must pay, each time a Covered Person receives certain medical services, procedures or items. The Plan's payment for those covered services or items begins after the copayment or coinsurance is satisfied. Covered services or items requiring a copayment or coinsurance are specified in this SPD.

For services provided by a network provider:

The amount which is listed as a percentage of charges or coinsurance is based on the network providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements. However, if a network providers' discounted charge for a service or item is less than the flat dollar copayment, you will pay the network providers' discounted charge. A copayment or coinsurance is due at the time a service is provided, or when billed by the provider.

For services provided by an out-of-network provider:

Any copayment or coinsurance is applied to the lesser of the providers' charge or the usual and customary charge for a service.

The copayment or coinsurance applicable for a scheduled visit with a network provider will be collected for each visit, late cancellation and failed appointment.

Deductible:

The specified dollar amount of charges incurred for covered services, which the Plan does not pay, but a Covered Person or a covered family has to pay first in a calendar year. The Plan's payment for those services or items begins after the deductible is satisfied. If you have a family deductible, each individual family member may only contribute up to the individual deductible amount toward the family deductible. An individual's copayments and coinsurance do not apply toward the family deductible. For network providers, the amount of charges that apply to the deductible are based on the network providers' discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule for case rate or withhold arrangements. For out-of-network providers, the amount of charges that apply to the deductible are the lesser of the providers' charges or the usual and customary charge for a service.

Deductible Carryover:

Charges incurred in the last three months of a calendar year, which are applied to any deductible for that calendar year, are carried over and applied toward any deductible for the following calendar year. The deductible carryover amount does not apply to the out-of-pocket limit for the following calendar year.

Lifetime Maximum Benefit:

The specified coverage limit paid for all Out-of-Network charges and actually paid for a Covered Person. Payment for Out-of-Network Benefits under the Plan ceases for that Covered Person when that limit is reached. The Covered Person has to pay for subsequent charges for Out-of-Network Benefits.

Out-of-Pocket Expenses:

You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to employee contributions.

Out-of-Pocket Limit:

You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter, 100% of charges incurred are covered under the Plan for all other covered services for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if any benefit maximums are exceeded or if the lifetime maximum is exceeded.

Out-of-Network Benefits for bariatric surgery do not apply to the out-of-pocket limit and will not be paid at 100% once the out-of-pocket limit has been met.

The reduction in benefits for failure to comply with CareCheck[®] requirements will not apply toward the out-of-pocket limit.

You are responsible to keep track of the out-of-pocket expenses. Contact HealthPartners Member Services department for assistance in determining the amount paid by the Covered Person for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the "Claims Procedures" section of the SPD.

	<u>Network Benefits</u>	<u>Out-of-Network Benefits</u>
Individual Calendar Year Deductible	\$250	\$250
Family Calendar Year Deductible	\$500	\$500
<i>The deductibles under the Network Benefits and the Out-of-Network Benefits are combined.</i>		
Individual Calendar Year Out-of-Pocket Limit	\$1,250	\$1,250
Family Calendar Year Out-of-Pocket Limit	\$2,500	\$2,500
<i>The out-of-pocket limits under the Network Benefits and the Out-of-Network Benefits are combined.</i>		
<i>Out-of-Network Benefits for bariatric surgery do not apply to the out-of-pocket limit and will not be paid at 100% once the out-of-pocket limit has been met.</i>		
<i>Any reduction in benefits for failure to comply with CareCheck[®] requirements will not apply toward the out-of-pocket limit.</i>		
Bariatric Surgery Lifetime Maximum Benefit	Unlimited	\$5,000
<i>Any benefits applied to the Bariatric Surgery Lifetime Maximum Benefit shown above will also apply towards the Lifetime Maximum Benefit described below.</i>		
Lifetime Maximum Benefit	Unlimited	\$2,000,000

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

***Network Benefits**

***Out-of-Network Benefits**

YOU MAY BE REQUIRED TO GET PRE-CERTIFICATION BEFORE USING CERTAIN OUT-OF-NETWORK SERVICES. SEE I.F. "CARECHECK®" IN THIS SPD FOR SPECIFIC INFORMATION ABOUT PRE-CERTIFICATION.

A. ACUPUNCTURE	80% of the charges incurred.	80% of the charges incurred.
B. AMBULANCE AND MEDICAL TRANSPORTATION	80% of the charges incurred.	See Network Benefits.
C. BEHAVIORAL HEALTH SERVICES		
Mental Health Services		
a. Outpatient Services, including day treatment, group therapy and intensive outpatient services	80% of the charges incurred.	80% of the charges incurred.
b. Inpatient Services, including psychiatric treatment for emotionally handicapped children	See Network Inpatient Hospital Services Benefit. <i>Limited to a 365 day maximum per period of confinement, subject to the combined day limit.</i>	See Out-of-Network Inpatient Hospital Services Benefit. <i>Limited to a 365 day maximum per period of confinement, subject to the combined day limit.</i>
Chemical Health Services		
a. Outpatient Services, including day treatment and intensive outpatient services	80% of the charges incurred. <i>The Plan covers supervised lodging at a contracted organization for Covered Persons actively involved in an affiliated licensed chemical dependency day treatment or intensive outpatient program for treatment of alcohol or drug abuse.</i>	80% of the charges incurred.
b. Inpatient Services	See Network Inpatient Hospital Services Benefit. <i>Limited to a 365 day maximum per period of confinement, subject to the combined day limit.</i>	See Out-of-Network Inpatient Hospital Services Benefit. <i>Limited to a 365 day maximum per period of confinement, subject to the combined day limit.</i>
D. CHIROPRACTIC SERVICES.	80% of the charges incurred.	80% of the charges incurred.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	<u>*Network Benefits</u>	<u>*Out-of-Network Benefits</u>
E. DENTAL SERVICES		
Accidental Dental Services	80% of the charges incurred.	80% of the charges incurred.
	<i>For all accidental dental services, treatment and/or restoration must be initiated within six months of the date of the injury. Coverage is limited to the initial course of treatment and/or initial restoration. Services must be provided within twenty-four months of the date of injury to be covered.</i>	
Medical Referral Dental Services		
a. Medically Necessary Outpatient Dental Services	80% of the charges incurred.	80% of the charges incurred.
b. Medically Necessary Hospitalization and Anesthesia for Dental Care	See Network Inpatient Hospital Services Benefit.	See Out-of-Network Inpatient Hospital Services Benefit.
	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>
c. Medical Complications of Dental Care	80% of the charges incurred.	80% of the charges incurred.
Oral Surgery	80% of the charges incurred.	80% of the charges incurred.
Orthognathic Surgery Benefit	80% of the charges incurred.	80% of the charges incurred.
Treatment of Cleft Lip and Cleft Palate of a Dependent Child	80% of the charges incurred.	80% of the charges incurred.
Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD)	80% of the charges incurred.	80% of the charges incurred.
F. DIAGNOSTIC IMAGING SERVICES		
<i>The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)</i>		
Associated with covered preventive services (MRI/CT procedures are not considered preventive)	Diagnostic imaging for preventive services is covered at the benefit level shown in the Preventive Services section.	
For illness or injury		
a. Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)	80% of the charges incurred.	80% of the charges incurred.
b. All other outpatient diagnostic imaging services	80% of the charges incurred.	80% of the charges incurred.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	<u>*Network Benefits</u>	<u>*Out-of-Network Benefits</u>
G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES	80% of the charges incurred.	80% of the charges incurred.
Special dietary treatment for Phenylketonuria (PKU)	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred.
Oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria	80% of the charges incurred.	80% of the charges incurred.
Wigs for alopecia areata	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.
	<i>Wigs for hair loss resulting from alopecia areata are subject to \$350 maximum payment per calendar year.</i>	
H. EMERGENCY AND URGENTLY NEEDED CARE SERVICES		
Urgently Needed care provided at clinics	80% of the charges incurred.	80% of the charges incurred.
Emergency care in a hospital emergency room, including professional services of a physician	80% of the charges incurred.	80% of the charges incurred.
Inpatient emergency care in a hospital	See Network Inpatient Hospital Services Benefit.	See Out-of-Network Inpatient Hospital Services Benefit.
	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>
	<i>Out-of-network professional fees will be paid at the Network Inpatient Hospital Services Benefit level if the Covered Person is admitted inpatient to a network hospital through the emergency room.</i>	
I. HEALTH EDUCATION	Health Education is covered at the benefit level shown in the Preventive Services section.	

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	<u>*Network Benefits</u>	<u>*Out-of-Network Benefits</u>
J. HOME HEALTH SERVICES		
Physical therapy, occupational therapy, speech therapy, respiratory therapy, home health aide services and palliative care	80% of the charges incurred.	80% of the charges incurred.
TPN/IV therapy, skilled nursing services, prenatal and postnatal services, child health services and phototherapy	80% of the charges incurred.	80% of the charges incurred.
K. HOME HOSPICE SERVICES		
	80% of the charges incurred.	80% of the charges incurred.
	<i>Respite care is limited to 5 days per episode, and respite care and continuous care combined are limited to 30 days.</i>	
L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES		
Medical or Surgical Hospital Services		
a. Inpatient Hospital Services	80% of the charges incurred.	80% of the charges incurred.
	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>	<i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>
	<i>Each Covered Person's admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other Covered Person.</i>	
b. Outpatient Hospital, Ambulatory Care or Surgical Facility Services (to see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy)	80% of the charges incurred.	80% of the charges incurred.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	<u>*Network Benefits</u>	<u>*Out-of-Network Benefits</u>
Skilled Nursing Facility Care	See Network Inpatient Hospital Services Benefit. <i>Limited to 120 day maximum per period of confinement, subject to the combined day limit.</i> <i>Each day of services provided under the Network Benefits and Out-of-Network Benefits, combined, counts toward the maximums shown above.</i>	See Out-of-Network Inpatient Hospital Services Benefit. <i>Limited to 120 day maximum per period of confinement, subject to the combined day limit.</i>
M. LABORATORY SERVICES <i>The Plan covers services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)</i>		
Associated with covered preventive services	Laboratory for preventive services is covered at the benefit level shown in the Preventive Services section.	
For illness or injury	80% of the charges incurred.	80% of the charges incurred.
N. MASTECTOMY RECONSTRUCTION BENEFIT	Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.	Coverage level is same as corresponding Out-of-Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury, Inpatient or Outpatient Hospital Services.
O. OFFICE VISITS FOR ILLNESS OR INJURY		
Office visits	80% of the charges incurred.	80% of the charges incurred.
Convenience clinics	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.
Scheduled telephone visits	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.
E-visits	80% of the charges incurred. Deductible does not apply.	80% of the charges incurred. Deductible does not apply.

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	<u>*Network Benefits</u>	<u>*Out-of-Network Benefits</u>
Injections administered in a physician's office		
Allergy injections	80% of the charges incurred.	80% of the charges incurred.
All other injections	80% of the charges incurred.	80% of the charges incurred.
Injectable and implantable birth control drugs/devices (this provision applies whether the birth control drug/device is used for birth control or for a medically necessary purpose other than birth control)	80% of the charges incurred.	80% of the charges incurred.
P. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY <i>The Plan covers services provided in a clinic. The Plan also covers physical therapy provided in an outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)</i>		
Rehabilitative therapy	80% of the charges incurred.	80% of the charges incurred. <i>Physical, Occupational and Speech therapy combined are limited to 15 visits per calendar year.</i>
Habilitative therapy	80% of the charges incurred.	80% of the charges incurred. <i>Physical, Occupational and Speech therapy combined are limited to 15 visits per calendar year.</i>
Q. PRESCRIPTION DRUG SERVICES		
	<i>ClearScript administers prescription drug services. For more information regarding this vendor, please contact your employer.</i>	
	Benefits for all outpatient prescription drugs and other pharmacy items, including but not limited to glucose monitors, diabetic supplies, growth hormone, blood products and blood derivatives are administered by another vendor. The benefits described in this Summary Plan Description only cover prescription drugs which are administered during an office visit, an emergency room or urgent care visit, an outpatient hospital visit or an inpatient stay.	

COVERED SERVICES. See Sections III. and IV. of this SPD for additional information about covered services and limitations.

	<u>*Network Benefits</u>	<u>*Out-of-Network Benefits</u>
R. PREVENTIVE SERVICES		
1. Routine health exams and periodic health assessments	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
2. Well child care	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
3. Routine prenatal services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
4. Routine postnatal services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
5. Routine screening procedures for cancer	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
6. Routine eye exams and contact lens fittings	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
7. Routine hearing exams	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
8. Professional voluntary family planning services	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
9. Adult immunizations	100% of the charges incurred. Deductible does not apply.	100% of the charges incurred. Deductible does not apply.
S. SPECIFIED OUT-OF-NETWORK SERVICES	Coverage level is same as corresponding Network Benefits, depending on the type of service provided, such as Office Visits for Illness or Injury.	See Network Benefits for the services covered.
T. TRANSPLANT SERVICES	See Network Inpatient Hospital Services Benefit. <i>Limited to 365 day maximum per period of confinement, subject to the combined day limit.</i>	No coverage.

SPECIFIC INFORMATION ABOUT THE PLAN

Employer:	City of Duluth
Name of the Plan:	The Plan shall be known as the City of Duluth Medical Benefit Plan which provides employee and dependent medical benefits
Address of the Plan:	402 City Hall 411 West First Street Duluth, MN 55802 218-730-5201
Group Number:	25077
Plan Year:	The period beginning on each January 1 in which the provisions of the Plan are in effect.
Plan Fiscal Year Ends:	December 31
Plan Sponsor: (is ultimately responsible for the management of the Plan; may employ or contract with persons or firms to perform day-to-day functions such as processing claims and performing other Plan-connected services.)	City of Duluth
Agent for Service of Legal Process:	General Counsel for City of Duluth
Named Fiduciary: (has the authority to control and manage the operation and administration of the Plan; has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.)	City of Duluth
Funding:	Claims under the Plan are paid from the general funds of the Employer.
Plan Manager: (provides administrative services to the Plan Sponsor in connection with the operation of the Plan, such as processing of claims and other functions, as may be delegated to it.)	HealthPartners Administrators, Inc. 8170 33 rd Avenue South P.O. Box 1309 Minneapolis, MN 55440-1309 (952) 883-6000
Network Providers:	NationalONE SM Network
Contributions:	Please refer to the most recent enrollment material for information regarding contributions to your Plan which is hereby incorporated by this reference.

HEALTHPARTNERS MISSION

OUR MISSION IS TO IMPROVE THE HEALTH OF OUR COVERED PERSONS, OUR PATIENTS AND THE COMMUNITY.

ABOUT HEALTHPARTNERS and YOUR EMPLOYER

HealthPartners Administrators, Inc. ("HPAI"). HPAI ("Plan Manager") is a third party administrator (TPA) which is a related organization of HealthPartners, Inc.

HealthPartners, Inc. ("HealthPartners"). HealthPartners is a Minnesota non-profit corporation and managed care organization.

Employer ("Plan Sponsor"). The Employer has established a Medical Benefit Plan ("the Plan") to provide medical benefits for Subscribers and their covered dependents ("Covered Persons"). The Plan is "self-insured" which means that the Plan Sponsor pays the claims from its own funding as expenses for covered services as they are incurred. The Plan is described in the Summary Plan Description ("SPD"). The Plan Sponsor has contracted with HPAI to provide access to its network of health care providers, claims processing, pre-certification and other Plan administration services. However, the Plan Sponsor is solely responsible for payment of your eligible claims.

Powers of the Plan Sponsor. The Plan Sponsor shall have all powers and discretion necessary to administer the Plan, including, without limitation, powers to: (1) interpret the provisions of the Plan; (2) establish and revise the method of accounting for the Plan; (3) establish rules and prescribe any forms required for administration of the Plan; (4) change the Plan; and (5) terminate the Plan.

The Plan Sponsor, by action of an authorized officer or committee, reserves the right to change the Plan. This includes, but is not limited to, changes to contributions, deductibles, copayments, out-of-pocket maximums, benefits payable and any other terms or conditions of the Plan. The Plan Sponsor's decision to change the Plan may be due to changes in applicable laws or for any other reason. The Plan may be changed to transfer the Plan's liabilities to another plan or split the Plan into two or more parts.

The Plan Sponsor shall have the power to delegate specific duties and responsibilities. Any delegation by the Plan Sponsor may allow further delegations by such individuals or entities to whom the delegation has been made. Any delegation may be rescinded by the Plan Sponsor at any time. Each person or entity to whom a duty or responsibility has been delegated shall be responsible for only those duties or responsibilities, and shall not be responsible for any act or failure to act of any other individual or entity.

No Guarantee of Employment. The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Plan Sponsor and any Subscriber. Nothing contained herein shall give any Subscriber the right to be retained in the employ of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Subscriber, any time, nor shall it give the Plan Sponsor the right to require any Subscriber to remain in its employ or to interfere with the Subscriber's right to terminate his or her employment at any time.

HealthPartners Trademarks. HealthPartners names and logos and all related products and service names, design marks and slogans are the trademarks of HealthPartners or its related companies.

I. INTRODUCTION TO THE SUMMARY PLAN DESCRIPTION

A. SUMMARY PLAN DESCRIPTION ("SPD")

This SPD, along with the Plan Manager's medical coverage criteria (available on-line at www.healthpartners.com or by calling Member Services), is your description of the Employer's Medical Benefit Plan ("the Plan"). It describes the Plan's benefits and limitations. Included in this SPD is a Schedule of Payments which states the amount payable for the covered services. Amendments which we include with this SPD or send you at a later date are fully made a part of this SPD.

This SPD should be read completely. Many of its provisions are interrelated; reading just one or two provisions may give you incomplete information regarding your rights and responsibilities under the Plan. Many of the terms used in this SPD have special meanings and are specifically defined in the SPD. Your SPD should be kept in a safe place for your future reference.

The Plan is maintained exclusively for Subscriber's and their covered dependents. Each Covered Person's rights under the Plan are legally enforceable. You may not assign or in any way transfer your rights under the Plan.

B. MEDICAL ADMINISTRATIVE SERVICES AGREEMENT ("ASA")

This SPD, together with the ASA between the Plan Sponsor and HPAI, as well as any amendments and any other documents referenced in the ASA, constitute the entire agreement between HPAI and the Plan Sponsor. The ASA is available for inspection at your Employer's office or at HealthPartners home office, at 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

C. CONFLICT WITH EXISTING LAW

In the event that any provision of this SPD is in conflict with applicable law, that provision only is hereby amended to conform to the minimum requirements of the law.

D. IDENTIFICATION CARD

An identification card will be issued to you at the time of enrollment. You and your covered dependents will be asked to present your identification card, or otherwise show that you are a Covered Person, whenever you seek services. You may not permit anyone else to use your card to obtain care.

E. HOW TO USE THE NETWORK

This SPD describes your covered services and how to obtain them. **The Plan provides Network Benefits and Out-of-Network Benefits from which you may choose to receive covered services.** Coverage may vary according to your network or provider selection. The provisions below contain information you need to know in order to obtain covered services.

Designated Physician, Provider, Facility or Vendor. This is a current list of network physicians, providers, facilities, or vendors which are authorized to provide certain covered services as described in this SPD. Call Member Services or visit HealthPartners.com for a current list.

Network Providers. This is any one of the participating licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies, which have entered into an agreement to provide health care services to Covered Persons.

Out-of-Network Providers. These are licensed physicians, dentists, mental and chemical health or other health care providers, facilities and pharmacies not participating as network providers.

ABOUT THE NETWORK

To obtain Network Benefits for covered services, you must select and receive services from network providers. If you are directed or referred by a network provider to an out-of-network provider, covered services will be paid at the Out-of-Network Benefits level.

Network. This is the network of participating network providers.

Continuity of Care. In the event you must change your current primary care physician, specialty care physician or general hospital provider because that provider leaves the network or because your Employer changed health plan offerings, you may have the right to continue receiving services from your current provider for a period of time. Some services provided by out-of-network providers may be considered a covered Network Benefit for up to 120 days under this contract if you qualify for continuity of care benefits.

Conditions that qualify for this benefit are:

1. an acute condition;
2. a life-threatening mental or physical illness;
3. pregnancy beyond the first trimester of pregnancy;
4. a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
5. a disabling or chronic condition that is in an acute phase.

You may also request continuity of care benefits for culturally appropriate services or when we do not have a provider who can communicate with you directly or through an interpreter. Terminally ill patients are also eligible for continuity of care benefits. Occasionally, HealthPartners may, in its sole discretion, apply a previous carrier's approach to coverage for a limited period of time to accommodate a member's specific needs for continuity of care when an employer is moving from another carrier to HealthPartners coverage.

Call Member Services for further information regarding continuity of care benefits.

Your physician may be required to obtain prior authorization for certain services. Your physician will coordinate the authorization process for any services which must first be authorized. You may call the Member Services Department or check on-line at www.healthpartners.com for a list of which services require your physician to obtain prior authorization.

HealthPartners medical or dental directors, or their designees, will determine medical necessity and appropriateness of certain treatments based on established medical policies, which are subject to periodic review and modification.

Your physician will obtain an authorization for (1) residential care for the treatment of eating disorders as an alternative to inpatient care in a licensed facility when medically necessary; (2) psychiatric residential treatment for emotionally handicapped children; and (3) mental health services provided in the home.

Contracted convenience care clinics are designated on www.healthpartners.com. You must use a designated convenience care clinic to obtain the convenience care benefit.

Durable medical equipment and supplies must be obtained from or repaired by designated vendors.

For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

To receive Network Benefits, weight loss surgery must be provided by a designated physician.

Multidisciplinary pain management must be provided at designated facilities.

Psychiatric residential treatment for emotionally handicapped children must be provided at designated facilities.

Call Member Services for more information on authorization requirements or designated vendors.

Second Opinions for Network Services. If you question a decision or recommendation about medical care, the Plan covers a second opinion from an appropriate network provider.

Prescription Drugs and Medical Equipment. Enrolling in the Plan does not guarantee that any particular prescription drug which is administered during an office visit, an emergency room or urgent care visit, an outpatient hospital visit or an inpatient stay will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment was available previously.

F. CARECHECK®

It is your responsibility to notify CareCheck® of all services requiring review, as shown in 1. below. Failure to follow CareCheck® procedures may result in a reduction of the maximum coverage available to you under the Plan. You can designate another person to contact CareCheck® for you.

1. **CARECHECK® Services.** CareCheck® is HealthPartners utilization review program for out-of-network services. CareCheck® must pre-certify all inpatient confinement and same day surgery, new, experimental or reconstructive outpatient technologies or procedures, durable medical equipment or prosthetics costing over \$3,000, home health services after your visits exceed 30 and skilled nursing facility stays. When you call CareCheck®, a utilization management specialist reviews your proposed treatment plan. CareCheck® provides certification and determines appropriate length of stay, additional days and reviews the quality and appropriateness of care.
2. **Procedure to Follow to Receive Maximum Benefits**
 - a. **For medical emergencies.** A certification request is to be made by phone to CareCheck® as soon as reasonably possible after the emergency. You will not be denied full coverage because of your failure to gain certification prior to your emergency.
 - b. **For medical non-emergencies.** A phone call must be made to CareCheck® when services requiring pre-certification are scheduled, but not less than 48 hours prior to that date. CareCheck® advises the physician and the hospital, or skilled nursing facility, by phone, if the request is approved. This will be confirmed by written notice within ten days of the decision.
3. **Failure to Comply with CareCheck® Requirements.** If you fail to make a request for pre-certification of services in the time noted above, but your services requiring pre-certification are subsequently approved as medically necessary, we will reduce the eligible charges by 15%.
4. **CareCheck® Certification Does Not Guarantee Benefits.** CareCheck® does not guarantee either payment or the amount of payment. Eligibility and payment are subject to all of the terms of the SPD. CareCheck® only certifies medical necessity.
5. **Information Needed When You Call CareCheck®.**

When you or another person contacts CareCheck®, this information is needed:

- the Covered Person's name, address, phone number, birth date and ID number;
- the attending physician's name, address, and phone number;
- the facility's name, address, and phone number;
- the reason for the services requiring review, as shown in a. above.

6. Pre-certification Process.

When a pre-certification for a non-urgent service is requested from HealthPartners, an initial determination must be made within 15 calendar days. This time period may be extended for an additional 15 calendar days, provided that the Plan Manager determines that such extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

When a pre-certification for an urgent service is requested from HealthPartners, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that the claimant has not provided all information necessary to make a decision, the claimant will be notified of such failure within 24 hours. The claimant will then be given 48 hours to provide the requested information. The claimant will be notified of the benefit determination within 48 hours after the earlier of HealthPartners receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

How to contact CareCheck®: You may call (952) 883-6400 in the Minneapolis/St. Paul metro area, or 1-800-316-9807 (toll-free) outside the metro area from 8:00 a.m. to 5:00 p.m. (Central Time) weekdays. You can leave a recorded message at other times. You may also write CareCheck® at Quality Utilization Management Department, 8170 33rd Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

G. ELIGIBILITY

Eligible Employees

All regular full time and part time active employees of the City of Duluth as defined in the bargaining agreements are eligible as specified in the Plan.

The following regular full-time active employees, appointed by the City of Duluth in the Legislative and Executive group, are eligible as specified in the Plan: City Attorney, Chief Administrative Officer, and the Mayor.

The effective date of coverage under this Plan is outlined in the Basic, CDSA, Confidential, Fire and Police bargaining agreements with the Employer. You must comply with requests made by the Employer and/or the Plan Manager to substantiate eligibility requirements of Plan participation. Your coverage under the Plan will be terminated for failure to provide requested information. Additionally, you are obligated to inform the Employer immediately of changes or events impacting eligibility in the Plan (e.g., divorce, death, etc.).

The respective bargaining agreements for the following entities will outline benefit plan eligibility, the waiting period, and effective date of coverage:

1. Duluth Airport Authority;
2. Duluth Entertainment Convention Center (DECC); and
3. Housing and Redevelopment Authority of Duluth (HRA).

This Plan covers only those employees who work in the United States or its Territories. Employees who work and reside in foreign countries are not eligible for coverage. Employees who are U.S. citizens or permanent residents of the U.S. working outside of the U.S. on a temporary basis are eligible.

Eligible Retirees

Retirees must contact the Plan Sponsor for eligibility requirements. You must comply with requests made by the Employer and/or the Plan Manager to substantiate eligibility requirements of Plan participation. Your coverage under the Plan will be terminated for failure to provide requested information. Additionally, you are obligated to inform the Employer immediately of changes or events impacting eligibility in the Plan (e.g., divorce, death, etc.).

Eligible Dependents

NOTE: If both you and your spouse are employees or retirees of the employer, DECC, HRA, or Airport you may be covered as either an employee/retiree or as a dependent, or both. Your eligible dependent children may be covered under either parent's coverage, or both.

You must comply with requests made by the Employer and/or the Plan Manager to substantiate eligibility requirements of Plan participation. Your coverage under the Plan will be terminated for failure to provide requested information. Additionally, you are obligated to inform the Employer immediately of changes or events impacting eligibility in the Plan (e.g., divorce, death, etc.).

Spouse

Married spouse, meaning legally married opposite gender spouse.

Dependent Children

1. Unmarried natural-born dependent children to age 26.
2. Unmarried legally adopted children and children placed with you for legal adoption to age 26. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.
3. Unmarried stepchildren to age 26 who live with you and who are claimed as exemptions on your Federal income tax return.
4. Unmarried dependent children for whom you or your spouse have been appointed legal guardian to age 26.
5. Unmarried grandchildren to age 26 who live with you continuously from birth and are financially dependent upon you.
6. Unmarried children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in Minnesota Statute §518.171. The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Plan Sponsor.

Disabled Dependents

1. Unmarried disabled dependent children who reach the limiting age while covered under this Plan if all of the following apply:
 - a. primarily dependent upon you;
 - b. are incapable of self-sustaining employment because of physical disability, mental retardation, mental illness, or mental disorders;
 - c. for whom application for extended coverage as a disabled dependent child is made within 31 days after reaching the age limit. After this initial proof, the Plan Manager may request proof again two (2) years later, and each year thereafter; and
 - d. must have become disabled prior to reaching limiting age.
2. Disabled dependents if both of the following apply:
 - a. incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and
 - b. chiefly dependent upon you for support and maintenance.

H. EFFECTIVE DATE OF COVERAGE

Coverage for you or your eligible dependents who were eligible on the effective date of the Plan will take effect on that date.

Adding New Employees

1. If the Plan Sponsor receives your application within 31 days after you become eligible, coverage for you and your eligible dependents starts on the first of the month following the date of eligibility. If the collective bargaining agreement (CBA) language differs, the effective date shall be governed by the CBA in force at the time of eligibility.
2. If the Plan Sponsor receives your application more than 31 days after you become eligible, you and your eligible dependents must reapply for coverage at the next annual open enrollment unless you meet the requirements of the special enrollment period.

Adding New Dependents

The section outlines the time period for application and the date coverage starts.

Adding spouse and/or stepchildren

1. If the Plan Sponsor receives the application within 31 days of the date of marriage, coverage for your spouse and/or stepchildren will be provided on the date your dependent(s) become eligible.
2. If the Plan Sponsor receives the application more than 31 days after the date of marriage, your spouse and/or stepchildren must reapply for coverage at the next annual open enrollment unless your spouse and/or stepchildren meet the requirements of the special enrollment period.

Adding newborns and children placed for adoption

The Plan Sponsor requests that you submit written application to add your newborn child or newborn grandchild within 31 days of the date of birth. Coverage for your newborn child or newborn grandchild starts on the date of birth.

The Plan Sponsor requests that you submit written application to add your adopted child within 31 days of the date of placement. Coverage for your adopted child starts on the date of placement.

Adding disabled children or disabled dependents

A disabled dependent may be added to the Plan if the disabled dependent is otherwise eligible under the Plan. Coverage starts the first of the month following the day the Plan Sponsor receives the application.

I. CHANGING PLAN COVERAGE

Eligible employees and retirees may add or delete dependents if they have a life qualifying event. The life qualifying events recognized by the Employer are:

1. adoption of a child;
2. birth of a child;
3. death of an employee or family member;
4. divorce;
5. employee change in employment status;
6. marriage;
7. Employee Open Enrollment (this event is applicable only to Employee annual open enrollment as specified by the Employer or a mid-year open enrollment specified by the Employer in the event of a contract settlement offering substantial benefit changes. Retirees do not participate in any open enrollment activities through the City of Duluth.);
8. spouse change in employment; or
9. unpaid leave of absence or Family Medical Leave (FMLA) taken by the employee or spouse.

J. SPECIAL ENROLLMENT PERIODS

Special enrollment periods are periods when an eligible employee or dependents may enroll in the Plan under certain circumstances **after they were first eligible for coverage**. The eligible circumstances are: 1.) a loss of other group health plan coverage; 2.) loss of Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) coverage; 3.) eligibility for premium assistance; or 4.) acquiring a new dependent. The request for enrollment must be within 31 days (unless otherwise noted) of the eligible circumstances.

Newborns, newborn grandchildren, and children placed for adoption are eligible as of the date of birth, adoption, or placement for adoption – See Eligible Dependents in the Eligibility section.

1. Loss of Group Health Plan Coverage

Employees or dependents who are eligible but not enrolled in the Plan may enroll for coverage under this Plan as special enrollees upon the loss of other health plan coverage if all of the following conditions are met:

- a. the employee or dependent was covered under a group health plan or other health insurance coverage at the time coverage was previously offered to the employee or dependent;
- b. the employee must complete any required written waiver of coverage and state in writing that, at such time, other health insurance coverage was the reason for declining enrollment;
- c. the employee's or dependent's coverage is terminated because his/her COBRA continuation has been exhausted (not due to failure to pay the premium or for cause), he/she is no longer eligible for the Plan due to legal separation, divorce, death of the employee, termination of employment, reduction in hours, cessation of dependent status, all employer contributions towards the coverage were terminated, the individual no longer lives or works in an HMO service area; and
- d. the employee or dependent requested enrollment not later than 31 days after the termination of coverage or employer contribution.

Coverage is effective the day after the termination of prior coverage.

2. Loss of Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) Coverage

Employees or dependents who are eligible but not enrolled in the Plan may enroll for coverage under this Plan as special enrollees upon the loss of Medicaid or CHIP coverage if all the following conditions are met:

- a. the employee or dependent was covered under Medicaid or CHIP at the time coverage was previously offered to the employee or dependent;
- b. the employee must complete any required written waiver of coverage and state in writing that, at such time, Medicaid or CHIP coverage was the reason for declining enrollment; and
- c. the employee or dependent must request enrollment no later than 60 days after the termination of Medicaid or CHIP coverage.

3. Eligibility for Premium Assistance

Employees or dependents who are eligible, but not enrolled in the Plan, may enroll for coverage under this Plan as special enrollees upon becoming eligible for premium assistance through the Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP) if all the following conditions are met:

- a. the employer must submit any required documentation indicating that the employee and/or dependents are eligible for premium assistance through Medicaid or CHIP; and
- b. the employee or dependent must request enrollment no later than 60 days after becoming eligible for premium assistance through Medicaid or CHIP.

4. Acquiring a New Dependent

Eligible employees who are either enrolled or not enrolled in the Plan may enroll themselves and newly acquired dependents for coverage under this Plan as special enrollees. If the employee is eligible under the terms of the Plan, the employee and eligible dependent are eligible for special enrollment when the employee acquires a new dependent through marriage, birth, adoption or placement for adoption.

Coverage is effective on the date of marriage, birth, adoption or placement for adoption, if application is received within 31 days after the marriage, birth, adoption or placement for adoption.

Dependent children other than the newly acquired dependent are not eligible for the special enrollment period.

K. TERMINATION EVENTS

Coverage ends on the earliest of the following dates:

1. For you and your dependents, the date on which the Plan terminates.
2. For you and your dependents, the last day of the month during which:
 - a. required charges for coverage were paid, if payment is not received when due. Your payment of charges to the employer does not guarantee coverage unless the Plan Manager receives full payment when due. If the Plan Manager terminates coverage for all employees in the Plan for nonpayment of the charges, the Plan Manager will give all employees a 30 day notice of termination prior to the effective date of cancellation using a list of addresses which is updated every 12 months.
 - b. you are no longer eligible.
 - c. you enter military services for duty lasting more than 31 days.
3. For the spouse, the date the spouse is no longer eligible for coverage. This is the last day of the month during which the employee and spouse divorce.
4. For a dependent child, the date the dependent child is no longer eligible for coverage. This is the last day of the month during which:
 - a. a covered stepchild is no longer eligible because the employee and spouse divorce;
 - b. the dependent child marries or reaches the dependent-child age limit;
 - c. the dependent child becomes covered as an employee under any health coverage plan sponsored by the employer;

- d. the disabled dependent is no longer eligible; or
- e. the dependent grandchild is no longer eligible.

To the extent that a termination would be considered a rescission under federal law under terms 2.b., 3 and 4. above, the Plan Sponsor is required to give the Covered Person 30 days advance notice of termination.

L. ACCESS TO RECORDS AND CONFIDENTIALITY

The Plan Sponsor complies with applicable State and Federal laws governing the confidentiality and use of protected health information and medical records. As part of this Summary Plan Description, the Plan Sponsor is authorized to have access to and use protected health information held by any health care provider who delivers health care services to you under this Summary Plan Description. The Plan Sponsor is also allowed to use your protected health information when necessary, for: certain health care operations including, but not limited to: claims processing, including claims made for reimbursement or subrogation; quality of care assessment and improvement; accreditation, credentialing, case management; care coordination and utilization management, disease management, underwriting, premium rating, claims experience reporting, the evaluation of potential or actual claims against the Plan Sponsor, auditing and legal services, and other access and use without further authorization if permitted or required by another law.

In the event that protected health information is disclosed to the Plan Sponsor, the Plan Sponsor may only use or disclose such information as permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated thereunder and as amended including, certain Plan administrative functions such as: claims review, subrogation, quality assurance, auditing, monitoring and management of carve out plans. Information may only be disclosed to the Plan Sponsor upon receipt, by the Plan, of a certification from the Plan Sponsor to the amendment of the Plan documents and that your Plan Sponsor agrees to:

- Not use or further disclose information except as listed above or as required or permitted by law;
- Ensure that any agents or subcontractors agree to the same restrictions and conditions that apply to your Employer or Plan Sponsor and that such agents and subcontractors agree to implement reasonable and appropriate security measures to protect electronic protected health information;
- Not use or disclose any information for employment – related actions or decisions;
- Not use or disclose any information in connection with any other employee benefit plan of your Employer or Plan Sponsor.
- Report to the Plan any security incident it becomes aware of and any use or disclosure of the information that is inconsistent with the uses or disclosures described above;
- Make information available to fulfill your right to access your protected health information;
- Make the information available for amendment or to incorporate applicable amendments;
- Make the information available in order to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of information received from the Plan available to the Department of Human Services to determine compliance with HIPAA.
- Return or destroy all protected health information received from the Plan, if feasible, when use or disclosure is no longer required. If return or destruction is not possible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure only certain classes of employees designated by your Employer are permitted access to your protected health information for Plan administration functions;
- Implement an effective mechanism for handling noncompliance by the employees designated access to your protected health information;
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that is created, received maintained or transmitted on behalf of the group health plan;
- Ensure adequate separation between the Plan and your Plan Sponsor is supported by reasonable and appropriate security measures.

M. YOUR RIGHT TO A CERTIFICATE OF COVERAGE UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA rules require Plan Sponsors to send Certificates of Coverage (also referred to as "HIPAA Certs" or "Certs") to all individuals currently or previously covered under their medical plan. The Plan Sponsor may elect to send their own or have their third party administrator/Plan Manager (HPAI) send Certificates of Coverage.

Certificates of Coverage are documents that provide evidence of your prior or current medical coverage. Certificates of Coverage reflect the length of continuous medical coverage that you had under the Plan Sponsors' Plan.

When your medical coverage is terminated, you will automatically be sent a Certificate of Coverage. You will also be sent a Certificate of Coverage anytime you request one. If you request a Certificate of Coverage while you have active medical coverage under the Plan, your Certificate of Coverage will indicate that your coverage is 'continuing'. You may request a Certificate of Coverage by calling Member Services phone number or writing to the address printed on your identification card.

According to HIPAA rules, Plan Sponsors must produce original Certificates of Coverage for a minimum of 24 months after the date that your medical coverage under the Plan Sponsors' Plan terminates.

II. DEFINITIONS OF TERMS USED

Admission. This is the medically necessary admission to an inpatient facility for the acute care of illness or injury.

Calendar Year. This is the 12-month period beginning 12:01 A.M. Central Time, on January 1, and ending 12:00 A.M. Central Time of the next following December 31.

CareCheck[®] Service. This is a pre-certification and utilization management program. It reviews, authorizes and coordinates the appropriateness and quality of care for certain benefits, as covered under the Out-of-Network Benefits of the Plan.

CareLineSM Service. This is a 24-hour telephone service which employs a staff of registered nurses who are available by phone to assist Covered Persons in assessing their need for medical care, and to coordinate after-hours care, as covered under the Plan.

Clinically Accepted Medical Services. These are techniques or services that have been determined to be effective for general use, based on risk and medical implications. Some clinically accepted medical services are approved only for limited use, under specific circumstances, as more fully described in this SPD.

Convenience Clinic. This is a clinic that offers a limited set of services and does not require an appointment.

Cosmetic Surgery. This is surgery to improve or change appearance (other than reconstructive surgery), which is not necessary to treat a related illness or injury.

Covered Dependent. This is the eligible dependent enrolled in the Plan.

Covered Person. This is the eligible and enrolled employee and each of his or her eligible and enrolled dependents covered for benefits under the Plan. When used in this SPD, "you" or "your" has the same meaning as Covered Person.

Covered Service. This is a specific medical or dental service or item, which is medically necessary or dentally necessary and covered by the Plan, as specifically described in this SPD.

Custodial Care. This is a supportive service focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to, bathing, dressing and feeding.

Dentally Necessary. This is care which is limited to diagnostic testing, treatment, and the use of dental equipment and appliances which, in the judgment of a dentist, is required to prevent deterioration of dental health, or to restore dental function. The Covered Person's general medical condition must permit the necessary procedure(s).

Dentist. A duly licensed doctor of dental surgery or dental medicine, lawfully performing a dental service in accordance with governmental licensing privileges and limitations.

Eligible Dependents. These are the persons shown in section I.G. Eligibility.

Emergency Accidental Dental Services. These are services required immediately, because of a dental accident.

Enrollment Date. This means the first day of coverage under the health benefit plan or the first day of the waiting period, if earlier.

Facility. This is a licensed medical center, clinic, hospital, skilled nursing facility or outpatient care facility, lawfully providing a medical service in accordance with applicable governmental licensing privileges and limitations.

Fiduciary. The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

Habilitative Care. This is speech, physical or occupational therapy which is rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development. To be considered habilitative, measurable functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward a Covered Person's maximum potential ability. The determination of whether such measurable progress has been made is within the sole discretion of the Plan's medical director or his or her designee, based on objective documentation.

Health Care Provider. This is any licensed non-physician (excluding naturopathic providers), lawfully performing a medical service in accordance with applicable governmental licensing privileges and limitations, who renders direct patient care to Covered Persons as covered under the Plan.

Home Hospice Program. This is a coordinated program of home-based, supportive and palliative care, for terminally ill patients and their families, to assist with the advanced stages of an incurable disease or condition. The services provided are comfort care and are not intended to cure the disease or medical condition, or to prolong life, in accordance with an approved home hospice treatment plan.

Hospital. This is a licensed facility, lawfully providing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility under the Plan. A hospital is not a nursing home or convalescent facility.

Inpatient. This is a medically necessary confinement for acute care of illness or injury, other than in a hospital's outpatient department, where a charge for room and board is made by the hospital or skilled nursing facility. The Plan covers a semi-private room, unless a physician recommends that a private room is medically necessary. In the event a Covered Person chooses to receive care in a private room under circumstances in which it is not medically necessary, payment under the Plan toward the cost of the room shall be based on the average semi-private room rate in that facility.

Investigative. As determined by HealthPartners, a drug, device or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness or effect on health outcomes. The following categories of reliable evidence will be considered, none of which shall be determinative by itself:

1. Whether there is final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the U.S. Food and Drug Administration (FDA); if the drug or device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials; or if the drug, device or medical treatment or procedure is under study or if further studies are needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and
2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether a drug is included in the American Hospital Formulary Service as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility studying the same drug, device, medical treatment or procedure.

Maintenance Care. This is supportive services, including skilled or non-skilled nursing care, to assist you when your condition has not improved or has deteriorated significantly over a measurable period of time (generally a period of two months). Care may be determined to be maintenance care regardless of whether your condition requires skilled medical care or the use of medical equipment.

Medically Necessary/Medically Necessary Care. This is health care services that are appropriate in terms of type, frequency, level, setting and duration to your diagnosis or condition, diagnostic testing and preventive services. Medically necessary care, as determined by the Plan, must be:

1. Appropriate for the symptoms, diagnosis or treatment of your medical condition;
2. Consistent with evidence-based standards of medical practice where applicable;
3. Not primarily for your convenience or that of your family, your physician, or any other person; and
4. The most appropriate and cost-effective level of medical services or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided in a lower level of care setting.

The fact that a physician, participating provider, or any other provider, has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed you of its availability, does not in itself make it medically necessary.

Medicare. This is the Federal government's health insurance program under Social Security Act Title XVIII, as amended. Medicare provides medical benefits to people who are 65 or older, or who are permanently disabled. The program has two parts: Part A and Part B. Part A generally covers the costs of hospitals and extended care facilities. Part B generally covers the costs of professional medical services. Both parts are subject to Medicare deductibles.

Mental Health Professional. This is a psychiatrist, psychologist, or mental health therapist licensed for independent practice, lawfully performing a mental or chemical health service in accordance with governmental licensing privileges and limitations, who renders mental or chemical health services to Covered Persons as covered under the Plan. For inpatient services, these mental health professionals must be working under the order of a physician.

Outpatient. This is medically necessary diagnosis, treatment, services or supplies rendered by a hospital's outpatient department, or a licensed surgical center and other ambulatory facility (other than in a physician's office).

Period of Confinement. This is (1) one continuous hospitalization, or (2) a series of hospitalizations or skilled nursing facility stays, or periods of time when the Covered Person is receiving home health services, for the same medical condition in which the end of one is separated from the beginning of the next by less than 90 days. For the purpose of this definition, "same condition" means illness or injury related to former illness or injury in that it is either within the same ascertainable diagnosis or set of diagnoses, or within the scope of complications or related conditions.

Physician. This is a licensed medical doctor, or doctor of osteopathy, lawfully performing a medical service, in accordance with governmental licensing privileges and limitations who renders medical or surgical care to Covered Persons as covered under the Plan.

Prescription Drug. This is any medical substance for the prevention, diagnosis or treatment of injury, disease or illness approved and/or regulated by the U.S. Food and Drug Administration (FDA). It must (1) bear the legend: "Caution: Federal law prohibits dispensing without a prescription" or "Rx Only"; and (2) be dispensed only by authorized prescription of any physician or legally authorized health care provider under applicable State law.

Pre-service Claim. This is any claim for a benefit under a group health plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. The only claims under this Plan that meet this definition are those claims that require pre-certification by CareCheck[®].

Reconstructive Surgery. This is limited to reconstructive surgery, incidental to or following surgery, resulting from injury or illness of the involved part, or to correct a congenital disease or anomaly resulting in functional defect in a dependent child. A functional defect is one that interferes with a Covered Person's ability to perform activities of daily living.

Rehabilitative Care. This is a restorative service, which is provided for the purpose of obtaining significant functional improvement, within a predictable period of time, (generally within a period of two months) toward a patient's maximum potential ability to perform functional daily living activities.

Skilled Nursing Facility. This is a licensed skilled nursing facility, lawfully performing medical services in accordance with governmental licensing privileges and limitations, and which is recognized as an appropriate facility by the Plan, to render inpatient post-acute hospital and rehabilitative care and services to Covered Persons, whose condition requires skilled nursing facility care. It does not include facilities which primarily provide treatment of mental or chemical health.

Subscriber. This is the eligible employee enrolled in the Plan.

Waiting Period. This is the period of time that an individual must wait before being eligible for coverage under the Plan.

III. DESCRIPTION OF COVERED SERVICES

The Plan covers the services described below and on the Schedule of Payments. The Schedule of Payments describes the level of payment that applies for each of the covered services. To be covered under this section, the medical or dental services or items described below must be medically necessary or dentally necessary.

Coverage is subject to the exclusions, limitations, and other conditions of this SPD.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available on-line at www.healthpartners.com or by calling Member Services.

A. ACUPUNCTURE

The Plan covers acupuncture services when medically necessary.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available on-line at www.healthpartners.com or by calling Member Services.

B. AMBULANCE AND MEDICAL TRANSPORTATION

The Plan covers certain ambulance and medical transportation for medical emergencies and as shown below.

For Network Benefits. Transfers between network hospitals for treatment by network physicians are covered, if initiated by a network physician. Transfers from a hospital or to home or to other facilities are covered, if medical supervision is required en route.

C. BEHAVIORAL HEALTH SERVICES

1. Mental Health Services

The Plan covers services for mental health diagnoses as described in the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM IV) (most recent edition) that lead to significant disruption of function in the Covered Person's life.

The Plan also provides coverage for mental health treatment ordered by a Minnesota court under a valid court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The Plan Manager must be given a copy of the court order and the behavioral care evaluation, and the service must be a covered benefit under this Plan, and the service must be provided by a network provider, or other provider as required by law. The Plan will cover the evaluation upon which the court order was based if it was provided by a network provider. The Plan also provides coverage for the initial mental health evaluation of a child, regardless of whether that evaluation leads to a court order for treatment, if the evaluation is ordered by a Minnesota juvenile court.

- a. **Outpatient Services.** The Plan covers outpatient professional mental health services for evaluation, crisis intervention, and treatment of mental health disorders.

A comprehensive diagnostic assessment will be made of each patient as the basis for a determination by a mental health professional, concerning the appropriate treatment and the extent of services required.

Outpatient services covered by the Plan for a diagnosed mental health condition include the following:

- (1) Individual, group, family, and multi-family therapy;
- (2) Medication management provided by a physician, certified nurse practitioner, or physician's assistant;
- (3) Psychological testing services for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services;
- (4) Day treatment and intensive outpatient services in a licensed program;
- (5) Partial hospitalization services in a licensed hospital or community mental health center; and
- (6) Psychotherapy and nursing services provided in the home if authorized by HealthPartners.

- b. **Inpatient Services:** The Plan covers inpatient services in a hospital and professional services for treatment of mental health disorders. Medical stabilization is covered under inpatient hospital services in the "Hospital and Skilled Nursing Facility Services" section.

The Plan covers residential care for the treatment of eating disorders in a licensed facility, as an alternative to inpatient care, when it is medically necessary and your physician obtains authorization from HealthPartners.

The Plan also covers Medically Necessary psychiatric residential treatment for emotionally handicapped children as diagnosed by a Physician. This care must be authorized by HealthPartners and provided by a hospital or residential treatment center licensed by the local state or Health and Human Services Department. The child must be under 18 years of age and an eligible dependent according to the terms of this SPD. Services not covered under this benefit include shelter services, correctional services, detention services, transitional services, group residential services, foster care services and wilderness programs.

2. Chemical Health Services

The Plan covers medically necessary services for assessments by a licensed alcohol and drug counselor and treatment of substance-related disorders as defined in the latest edition of the DSM IV.

- a. **Outpatient Services including day treatment and intensive outpatient services.** The Plan covers outpatient professional services for diagnosis and treatment of chemical dependency. Chemical dependency treatment services must be provided by a program licensed by the local Health and Human Services Department.

Outpatient services covered by the Plan for a diagnosed chemical dependency condition include the following:

- (1) Individual, group, family, and multi-family therapy provided in an office setting;
- (2) Opiate replacement therapy including methadone and buprenorphine treatment; and
- (3) Day treatment and intensive outpatient services in a licensed program.

- b. **Inpatient Services:** The Plan covers inpatient services in a hospital or a licensed residential primary treatment center.

The Plan covers services provided in a hospital that is licensed by the local State and accredited by Medicare.

Detoxification Services. The Plan covers detoxification services in a hospital or community detoxification facility if it is licensed by the local Health and Human Services Department.

Covered services are based on established medical policies, which are subject to periodic review and modification by the medical directors. These medical policies (medical coverage criteria) are available on-line at www.healthpartners.com or by calling Member Services.

D. CHIROPRACTIC SERVICES

The Plan covers chiropractic services for rehabilitative care, rendered to diagnose and treat acute neuromuscular-skeletal conditions.

Massage therapy which is performed in conjunction with other treatment/modalities by a chiropractor and is part of a prescribed treatment plan and is not billed separately is covered.

E. DENTAL SERVICES

- 1. Accidental Dental Services.** The Plan covers dentally necessary services to treat and restore damage done to sound, natural, unrestored teeth as a result of an accidental injury. Coverage is for damage caused by external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing. When an implant-supported dental prosthetic treatment is pursued, the accidental dental benefit will be applied to the prosthetic procedure. Benefits are limited to the amount that would be paid toward the placement of a removable dental prosthetic appliance that could be used in the absence of implant treatment.
- 2. Medical Referral Dental Services.**
 - a. Medically Necessary Outpatient Dental Services.** The Plan covers certain medically necessary outpatient dental services. Coverage is limited to dental services required for treatment of an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions.
 - b. Medically Necessary Hospitalization and Anesthesia for Dental Care.** The Plan covers certain medically necessary hospitalization for dental care. This is limited to charges incurred by a Covered Person who: (1) is a child under age 5; (2) is severely disabled; (3) has a medical condition, and requires hospitalization or general anesthesia for dental care treatment; or (4) is a child between age 5 and 12 and care in dental offices has been attempted unsuccessfully and usual methods of behavior modification have not been successful, or when extensive amounts of restorative care, exceeding 4 appointments, are required. The requirement of a hospital setting must be due to a Covered Person's underlying medical condition. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist professional fees are not covered. The following are examples, though not all-inclusive, of medical conditions which may require hospitalization for dental services: severe asthma, severe airway obstruction or hemophilia. Hospitalization required due to the behavior of the Covered Person or due to the extent of the dental procedure is not covered.
 - c. Medical Complications of Dental Care.** The Plan covers certain medical complications of dental care. Treatment must be medically necessary care and related to significant medical complications of non-covered dental care, including complications of the head, neck, or substructures.
- 3. Oral Surgery.** The Plan covers certain oral surgery. Coverage is limited to treatment of medical conditions requiring oral surgery, such as treatment of oral neoplasm, non-dental cysts, fracture of the jaws, and trauma of the mouth and jaws.
- 4. Orthognathic Surgery Benefit.** The Plan covers orthognathic surgery for the treatment of severe dysmorphia where a functional occlusion can not be achieved through non-surgical treatment alone and where a demonstrable functional impairment exists. Functional impairments include but are not limited to significant impairment in chewing, breathing or swallowing. Associated dental or orthodontic services (pre or post operatively including surgical rapid palatal expansion) are not covered as a part of this benefit.

5. **Treatment of Cleft Lip and Cleft Palate.** The Plan covers certain treatment of cleft lip and cleft palate of a dependent child, to the limiting age in the definition of an “eligible dependent”, including orthodontic treatment and oral surgery directly related to the cleft. Benefits for individuals up to age 26 for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. Dental services which are not necessary for the treatment of cleft lip or cleft palate are not covered. If a dependent child covered under the Plan is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment, conditions and limitations as durable medical equipment.
6. **Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD).** The Plan covers surgical and non-surgical treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD), when such care is medically necessary. Dental services which are not required to directly treat TMD or CMD are not covered.

F. DIAGNOSTIC IMAGING SERVICES

The Plan covers diagnostic imaging, when ordered by a provider and provided in a clinic or outpatient hospital facility.

For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

The Plan covers certain equipment and services, as described below.

1. Subject to the limitations below, the Plan covers durable medical equipment (including insulin pumps and insulin pump supplies, glucose monitors/meters and their supplies when purchased from a durable medical equipment vendor) and orthotic benefits, including certain disposable supplies. This benefit does not cover diabetic supplies including, but not limited to, needles, lancets and test strips purchased at a pharmacy or Durable Medical Equipment (DME) vendor.

We cover special dietary treatment for Phenylketonuria (PKU) and oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria.

External hearing aids (including osseointegrated or bone anchored) for Covered Persons to age 19 or younger who have hearing loss that is not correctable by other covered procedures. Coverage is limited to one hearing aid for each ear every three years.

2. Coverage of durable medical equipment is limited by the following:
 - a. Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary.
 - b. For prosthetic benefits, other than hair prostheses (i.e. wigs) for hair loss resulting from alopecia areata and oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary and enables Covered Persons to conduct standard activities of daily living.
 - c. The Plan reserves the right to determine if an item will be approved for rental vs. purchase.
3. Items which are not eligible for coverage include, but are not limited to:
 - a. Replacement or repair of any covered items, if the items are: (1) damaged or destroyed by misuse, abuse or carelessness; (2) lost; or (3) stolen.
 - b. Duplicate or similar items.
 - c. Labor and related charges for repair of any covered items which are more than the cost of replacement by a designated vendor.
 - d. Sales tax, mailing, delivery charges, service call charges.

- e. Items which are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation.
- f. Communication aids or devices: equipment to create, replace or augment communication abilities including, but not limited to, hearing aids (implantable and external, including osseointegrated or bone anchored), fitting of hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication, except as specifically described in this SPD. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or on-line at www.healthpartners.com.
- g. Household equipment which primarily has customary uses other than medical, such as, but not limited to, exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses or waterbeds.
- h. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools, whirlpools and saunas.
- i. Modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment.
- j. Vehicle, car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carriers.
- k. Rental equipment while the Covered Person's owned equipment is being repaired, beyond one month rental of medically necessary equipment.
- l. Other equipment and supplies, including but not limited to assistive devices, that the Plan determines are not eligible for coverage.

Durable medical equipment and supplies must be obtained from or repaired by designated vendors.

Covered services and supplies are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. The coverage policy for diabetic supplies includes information on the required models and brands. These medical policies (medical coverage criteria) are available on-line at www.healthpartners.com or by calling Member Services.

H. EMERGENCY AND URGENTLY NEEDED CARE SERVICES

Emergency Care. These are services to treat: (1) the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization; or (2) a condition requiring professional health services immediately necessary to preserve life or stabilize health.

When reviewing claims for coverage of emergency services, a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment will be taken into consideration.

Urgently Needed Care. These are services to treat an unforeseen illness or injury, which are required in order to prevent a serious deterioration in the Covered Person's health, and which cannot be delayed until the next available clinic or office hours.

The Plan covers services for emergency care and urgently needed care if the services are otherwise eligible for coverage in this SPD.

I. HEALTH EDUCATION

The Plan covers education for preventive services and education for the management of chronic health problems (such as diabetes).

J. HOME HEALTH SERVICES

The Plan covers skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy and other therapeutic services, prenatal and postnatal services, child health supervision services, phototherapy services for newborns, home health aide services and other eligible home health services when rendered in the Covered Person's home, if the Covered Person is homebound (i.e., unable to leave home without considerable effort due to a medical condition. Lack of transportation does not constitute homebound status.). For phototherapy services for newborns and high risk pre-natal services, supplies and equipment are included.

The Plan covers total parenteral nutrition/intravenous ("TPN/IV") therapy, equipment, supplies and drugs in connection with IV therapy. IV line care kits are covered under Durable Medical Equipment.

The Plan covers palliative care benefits. Palliative care includes symptom management, education and establishing goals for care. The requirement that the Covered Person is homebound will be waived for a limited number of home visits for palliative care (as shown in the Schedule of Payments), if you have a life-threatening, non-curable condition which has a prognosis of two years or less. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements defined in this section.

You do not need to be homebound to receive total parenteral nutrition/intravenous ("TPN/IV") therapy.

Home health services are eligible and covered only when they are:

1. medically necessary; and
2. provided as rehabilitative or terminal care; and
3. ordered by a physician, and included in the written home care plan.

Home health services are not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home. The Plan will not reimburse family members or residents in the Covered Person's home for the above services.

A service shall not be considered a skilled nursing service merely because it is performed by, or under the direct supervision of, a licensed nurse. Where a service (such as tracheotomy suctioning or ventilator monitoring or like services) can be safely and effectively performed by a non-medical person (or self-administered), without the direct supervision of a licensed nurse, the service shall not be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled nursing component of so-called "blended" services (i.e., services which include skilled and non-skilled components) are covered under the Plan.

K. HOME HOSPICE SERVICES

Applicable Definitions:

Part-time. This is up to two hours of service per day; more than two hours per day is considered continuous care.

Continuous Care. This is from two to twelve hours of service per day provided by a registered nurse, licensed practical nurse, or home health aide, during a period of crisis in order to maintain a terminally ill patient at home.

Appropriate Facility. This is a nursing home, hospice residence or other inpatient facility.

Custodial Care Related to Hospice Services. This means providing assistance in the activities of daily living and the care needed by a terminally ill patient which can be provided by a primary caregiver (i.e., family member or friend) who is responsible for the patient's home care.

1. **Home Hospice Program.** The Plan covers the services described below for Covered Persons who are terminally ill patients and accepted as home hospice program participants. Covered Persons must meet the eligibility requirements of the program, and elect to receive services through the home hospice program. The services will be provided in the patient's home, with inpatient care available when medically necessary as described below. Covered Persons who elect to receive hospice services do so in lieu of curative treatment for their terminal illness for the period they are enrolled in the home hospice program.
 - a. **Eligibility:** In order to be eligible to be enrolled in the home hospice program, a Covered Person must: (1) be a terminally ill patient (prognosis of six months or less); (2) have chosen a palliative treatment focus (i.e., emphasizing comfort and supportive services rather than treatment attempting to cure the disease or condition); and (3) continue to meet the terminally ill prognosis as determined by HealthPartners medical director or his or her designee over the course of care. A Covered Person may withdraw from the home hospice program at any time.
 - b. **Eligible Services:** Hospice services include the following services provided by Medicare-certified providers, if provided in accordance with an approved hospice treatment plan.
 - (1) **Home Health Services:**
 - (a) Part-time care provided in the Covered Person's home by an interdisciplinary hospice team (which may include a physician, nurse, social worker, and spiritual counselor) and medically necessary home health services are covered.
 - (b) One or more periods of continuous care in the Covered Person's home or in a setting which provides day care for pain or symptom management, when medically necessary, will be covered.
 - (2) **Inpatient Services:** The Plan covers medically necessary inpatient services.
 - (3) **Other Services:**
 - (a) Respite care is covered for care in the Covered Person's home or in an appropriate facility, to give the patient's primary caregivers (i.e., family members or friends) rest and/or relief when necessary in order to maintain a terminally ill patient at home.
 - (b) Medically necessary semi-electric hospital beds and other durable medical equipment are covered.
 - (c) Medically necessary emergency and non-emergency care are covered.
2. **What Is Not Covered.** The Plan does not cover the following services:
 - a. financial or legal counseling services; or
 - b. housekeeping or meal services in the patient's home; or
 - c. custodial care related to hospice services, whether provided in the home or in a nursing home; or
 - d. any service not specifically described as a covered service under this home hospice services section; or
 - e. any services provided by a member of the patient's family or resident in the Covered Person's home.

L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

1. Medical or Surgical Hospital Services

- a. **Inpatient Hospital Services.** The Plan covers the following medical or surgical services, for the treatment of acute illness or injury, which require the level of care only provided in an acute care facility. These services must be authorized by a physician.

Inpatient hospital services include: room and board; the use of operating or maternity delivery rooms; intensive care facilities; newborn nursery facilities; general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, prescription drugs or other medications administered during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or treatment related hospital services; physician and other professional medical and surgical services provided while in the hospital.

The Plan covers up to 120 hours of services provided by a private duty nurse or personal care assistant who has provided home care services to a ventilator-dependent patient, solely for the purpose of assuring adequate training of the hospital staff to communicate with that patient.

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Sponsor.

Services or items for personal convenience, such as television rental, are not covered.

- b. **Outpatient Hospital, Ambulatory Care or Surgical Facility Services.** The Plan covers the following medical and surgical services, for diagnosis or treatment of illness or injury on an outpatient basis. These services must be authorized by a physician.

Outpatient services include: use of operating rooms, maternity delivery rooms or other outpatient departments, rooms or facilities; and the following outpatient services: general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, drugs administered during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or treatment related outpatient services; physician and other professional medical and surgical services rendered while an outpatient.

For Network Benefits, non-emergency, scheduled outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) must be provided at a designated facility.

To see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see the benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy in the Schedule of Payments.

2. Skilled Nursing Facility Care.

The Plan covers room and board, daily skilled nursing and related ancillary services for post acute treatment and rehabilitative care of illness or injury, following a hospital confinement.

M. LABORATORY SERVICES

The Plan covers laboratory tests when ordered by a provider and provided in a clinic or outpatient hospital facility.

N. MASTECTOMY RECONSTRUCTION BENEFIT

The Plan covers reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

O. OFFICE VISITS FOR ILLNESS OR INJURY

The Plan covers the following when medically necessary: professional medical and surgical services and related supplies, including biofeedback, of physicians and other health care providers, and blood and blood products (unless replaced) and blood derivatives.

The Plan also covers diagnosis and treatment of illness or injury to the eyes. Where contact or eyeglass lenses are prescribed as medically necessary for the post-operative treatment of cataracts or for the treatment of aphakia or keratoconus, the initial evaluation, lenses and fitting are covered under the Plan. Covered Persons must pay for lens replacement beyond the initial pair.

The Plan also provides coverage for the initial physical evaluation of a child if it is ordered by a Minnesota juvenile court.

P. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY

The Plan covers the following physical therapy, occupational therapy and speech therapy services:

1. Rehabilitative care to correct the effects of illness or injury.
2. Habilitative care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development.

Massage therapy which is performed in conjunction with other treatment/modalities by a physical or occupational therapist and is part of a prescribed treatment plan and is not billed separately is covered.

Q. PRESCRIPTION DRUG SERVICES

The benefits described in this SPD cover only those prescription drugs and medications which are administered in a physician's office, during an emergency room or urgent care visit, an outpatient hospital visit or an inpatient stay. Please note benefits for all outpatient prescription drugs and other pharmacy items are administered by another vendor. For more information regarding this vendor, please contact your employer.

R. PREVENTIVE SERVICES

The Plan covers the following preventive services:

1. Routine health exams and periodic health assessments. A physician or health care provider will counsel Covered Persons as to how often health assessments are needed based on the age, sex and health status of the Covered Person.
2. Well child care, including pediatric preventive services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months, and appropriate immunizations to age 18.
3. Routine prenatal care and exams to include visit-specific screening tests, education and counseling.
4. Routine postnatal care and exams to include health exams, assessments, education and counseling relating to the period immediately after childbirth.
5. Routine screening procedures for cancer.
6. Routine eye exams and contact lens fittings.
7. Routine hearing exams.
8. Professional voluntary family planning services.
9. Adult immunizations.

Covered services are based on established medical policies, which are subject to periodic review and modification by the medical or dental directors. These medical policies (medical coverage criteria) are available on-line at www.healthpartners.com or by calling Member Services.

S. SPECIFIED OUT-OF-NETWORK SERVICES

The Plan covers the following services, when a Covered Person elects to receive them from an out-of-network provider, at the same level of coverage the Plan provides when a Covered Person elects to receive the services from a network provider:

1. Voluntary family planning of the conception and bearing of children.
2. Testing and treatment of sexually transmitted diseases (other than HIV).
3. Testing for AIDS and other HIV-related conditions.

T. TRANSPLANT SERVICES

Autologous. This is when the source of cells is from the individual's own marrow or stem cells.

Allogeneic. This is when the source of cells is from a related or unrelated donor's marrow or stem cells.

Autologous Bone Marrow Transplant. This is when the bone marrow is harvested from the individual and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is then reinfused (transplanted).

Allogeneic Bone Marrow Transplant. This is when the bone marrow is harvested from a donor and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is reinfused (transplanted).

Autologous/Allogeneic Stem Cell Support. This is a treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell reinfusion, and related care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

Designated Transplant Center. This is any health care provider, group or association of health care providers designated by the Plan to provide services, supplies or drugs for specified transplants for Covered Persons.

Transplant Services. This is transplantation (including retransplants) of the human organs or tissue listed below, including related post-surgical treatment and multiple transplants for a related cause. Transplant services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of FDA approved Ventricular Assist Devices (VAD), functioning as a temporary bridge to heart transplantation.

What is Covered. The Plan covers eligible transplant services (as defined above) while you are a Covered Person. Transplants that will be considered for coverage are limited to the following:

1. Kidney transplants for end-stage disease.
2. Cornea transplants for end-stage disease.
3. Heart transplants for end-stage disease.
4. Lung transplants or heart/lung transplants for: (a) primary pulmonary hypertension; (b) Eisenmenger's syndrome; (c) end-stage pulmonary fibrosis; (d) alpha 1 antitrypsin disease; (e) cystic fibrosis; and (f) emphysema.
5. Liver transplants for: (a) biliary atresia in children; (b) primary biliary cirrhosis; (c) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (d) primary sclerosing cholangitis; (e) alcoholic cirrhosis; and (f) hepatocellular carcinoma.
6. Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (a) acute myelogenous leukemia; (b) acute lymphocytic leukemia; (c) chronic myelogenous leukemia; (d) severe combined immunodeficiency disease; (e) Wiskott-Aldrich syndrome; (f) aplastic anemia; (g) sickle cell anemia; (h) non-relapsed or relapsed non-Hodgkin's lymphoma; (i) multiple myeloma; and (j) testicular cancer.
7. Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (a) acute leukemias; (b) non-Hodgkin's lymphoma; (c) Hodgkin's disease; (d) Burkitt's lymphoma; (e) neuroblastoma; (f) multiple myeloma; (g) chronic myelogenous leukemia; and (h) non-relapsed non-Hodgkin's lymphoma.
8. Pancreas transplants for simultaneous pancreas-kidney transplants for diabetes, pancreas after kidney, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone.

To receive Network Benefits, charges for transplant services must be incurred at a designated transplant center.

The transplant-related treatment provided, including the expenses incurred for directly related donor services, shall be subject to and in accordance with the provisions, limitations, maximums and other terms of this SPD.

Medical and hospital expenses of the donor are covered only when the recipient is a Covered Person and the transplant and directly related donor expenses have been prior authorized for coverage. Treatment of medical complications that may occur to the donor are not covered. Donors are not considered Covered Persons, and are therefore not eligible for the rights afforded to Covered Persons under this SPD.

The list of eligible transplant services and coverage determinations are based on established medical policies which are subject to periodic review and modification by HealthPartners medical director.

IV. SERVICES NOT COVERED

In addition to any other benefit exclusions, limitations or terms specified in this SPD, the Plan will not cover charges incurred for any of the following services, except as specifically described in this SPD:

1. Treatment, procedures, services or drugs which are not medically necessary and/or which are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the Covered Person, including cognitive retraining and skills training.
2. Procedures, technologies, treatments, facilities, equipment, drugs and devices which are considered investigative, or otherwise not clinically accepted medical services. The Plan considers vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and does not cover these services. The Plan considers the following transplants to be investigative and does not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this SPD. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered.
3. Rest and respite services and custodial care. This includes all services, medical equipment and drugs provided for such care.
4. Room and board and care provided in halfway houses, residential treatment services, extended care facilities, or comparable facilities, foster care, adult foster care and family child care provided or arranged by the local state or county.
5. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs and supplies.
6. Services from non-medically licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.
7. Cosmetic surgery, cosmetic services and treatments primarily for the improvement of the Covered Person's appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for port wine stain removal and reconstructive surgery.
8. All services for weight loss programs and drugs.
9. Dental treatment, procedures or services not listed in this SPD.
10. Vocational rehabilitation and recreational or educational therapy.
11. Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies.
12. Reversal of sterilization; assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and/or in-vitro fertilization (IVF), and all charges associated with such procedures; treatment of infertility; artificial insemination; surrogate pregnancy and related obstetric/maternity benefits; and sperm, ova or embryo acquisition, retrieval or storage.
13. Services and/or surgery for gender reassignment.
14. Maintenance chiropractic therapy.
15. Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and hearing aids (implantable and external, including osseointegrated or bone anchored) and their fitting, except as specifically described in this SPD. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. Medical coverage criteria are available by calling Member Services, or on www.healthpartners.com.
16. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as specified in this SPD. This exclusion does not apply to oral amino acid based elemental formula if it meets HealthPartners medical coverage criteria.
17. Charges for sales tax.
18. Services provided by a family member of the Covered Person, or a resident in the Covered Person's home.
19. Religious counseling, marital/relationship counseling and sex therapy.
20. Private duty nursing services.

21. Services that are rendered to a Covered Person, who also has other primary insurance coverage for those services and who does not provide the Plan the necessary information to pursue coordination of benefits, as required under the Plan.
22. The portion of a billed charge for an otherwise covered service by a provider, which is in excess of the usual and customary charges, or which is either a duplicate charge for a service or charges for a duplicate service.
23. Charges for services (a) for which a charge would not have been made in the absence of insurance or medical plan coverage, or (b) which the Covered Person is not legally obligated to pay, and (c) from providers who waive copayment, deductible and coinsurance payments by the Covered Person.
24. Travel and lodging incidental to travel, regardless if it is recommended by a physician and any travel billed by a provider.
25. Health club memberships.
26. Massage therapy for the purpose of a Covered Person's comfort or convenience.
27. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft.
28. Autopsies.
29. Accident related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) initiated beyond six months from the date of the injury, (4) received beyond the initial treatment or restoration, or (5) received beyond twenty-four months from the date of injury.
30. Nonprescription (over-the-counter) drugs or medications, unless listed on the preferred drug list and prescribed by a physician or legally authorized health care provider under applicable State law, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs.
31. Intensive behavioral therapy treatment programs for the treatment of autism spectrum disorders, including ABA, IEIBT, and Lovaas.
32. Charges for elective home births.
33. Professional services associated with substance abuse intervention. A "substance abuse intervention" is a gathering of family and/or friends to encourage a person covered under this SPD to seek substance abuse treatment.
34. For Network Benefits, charges incurred for transplants, Magnetic Resonance Imaging (MRI) and Computing Tomography (CT) received at facilities which are not designated facilities, or charges incurred for weight loss services provided by a physician who is not a designated physician.
35. Court ordered treatment, except as described under "Mental Health Services" and "Office Visits for Illness and Injury" or as otherwise required by law.
36. Services provided by naturopathic providers.
37. Oral surgery to remove wisdom teeth.
38. Treatment, procedures, or services or drugs which are provided when you are not covered under this Plan.
39. Drugs for the treatment of growth deficiency.
40. All prescription drugs, medications or pharmacy items other than those administered in a physician's office, during an emergency room or urgent care visit, an outpatient hospital visit or an inpatient stay or unless otherwise specified in this SPD.
41. Charges for transplant services received Out-of-Network or by a non-designated transplant center.
42. Elective abortions, except in situations where the life of the mother would be endangered if the fetus is carried to full term.

V. DISPUTES AND COMPLAINTS

A. DETERMINATION OF COVERAGE

Eligible services are covered only when medically necessary for the proper treatment of a Covered Person. HealthPartners medical or dental directors, or their designees, make coverage determinations of medical necessity, restrictions on access and appropriateness of treatment; however, the Plan Sponsor will make final authorization for Covered Services.

Coverage determinations are based on established medical policies, which are subject to periodic review and modification by HealthPartners medical or dental directors.

If your claim for medical services was denied based on HealthPartners clinical coverage criteria, you or your provider can discuss the decision with a clinician who reviewed the request for coverage. Call Member Services for assistance.

B. COMPLAINTS

The Plan has a complaint procedure to resolve complaints and disputes. Complaints should be made in writing or orally. They may concern the provision of care by network providers, administrative actions, or claims related to the Plan, including breach, meaning or termination. The complaint system seeks to resolve a dispute which arose during the time of your coverage, or application for coverage.

Complaints must be made to:

HealthPartners

Member Services Department

8170 33rd Avenue South, P.O. Box 1309

Minneapolis, MN 55440-1309

Telephone: (952) 883-5000 Outside the metro area: 1-800-883-2177 toll-free

TDD Telephone Number: (952) 883-5127 Outside the metro area: 1-888-850-4762 toll-free

VI. CONDITIONS

A. RIGHTS OF REIMBURSEMENT AND SUBROGATION

If services are provided or paid for under the Plan to treat an injury or illness: (1) caused by the act or omission of another party; (2) covered by no fault or employers liability laws; (3) available or required to be furnished by or through national or State governments or their agencies; or (4) sustained on the property of a third party, the Plan Sponsor or its designee has the right to recover the reasonable value of services and payments made. This right shall be by reimbursement and subrogation. The right of reimbursement means you must repay the Plan Sponsor or its designee at the time you make any recovery. Recovery means all amounts received by you from any persons, organizations or insurers by way of settlement, judgment, award or otherwise on account of such injury or illness. The right of subrogation means that the Plan Sponsor or its designee may make claim in your name or the Plan Sponsor's name against any persons, organizations or insurers on account of such injury or illness. Attorneys' fees and expenses incurred by a Covered Person in connection with the recovery of monies from third parties may not be deducted from subrogation/reimbursement amounts, unless agreed to by the Plan Sponsor in its discretion.

In addition, the Plan will have a lien on any amounts payable by a third party or under an insurance policy or program, to the extent covered expenses are paid by the Plan Sponsor's Medical Benefit Plan.

The rights of reimbursement and subrogation apply whether or not the Covered Person has been fully compensated for losses or damages by any recovery of payments, and the Plan Sponsor or its designee will be entitled to immediately collect the present value of subrogation rights from said payments.

If, after recovery of any payments, you receive services or incur expenses on account of such injury or illness, you may be required to pay for such services or expenses. The total of all reimbursement and payments will not exceed your recovery.

This right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, medical payments coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery. The right of reimbursement is binding upon you, your legal representative, your heirs, next of kin and any trustee or legal representative of your heirs or next of kin in the event of your death. Any amounts you receive from such a recovery must be held in trust for the Plan's benefit to the extent of subrogation claims.

You agree to cooperate fully in every effort by the Plan Sponsor or its designee to enforce the rights of reimbursement and subrogation. You also agree that you will not do anything to interfere with those rights. You agree to promptly inform the Plan Sponsor in writing of any situation or circumstance which may allow the Plan Sponsor to invoke its rights under this section.

B. COORDINATION OF BENEFITS

You agree, as a Covered Person, to permit the Plan Manager to coordinate payments under any other medical benefit plans as specified below, which cover you or your dependents. You also agree to provide any information or submit any claims to other medical benefit plans necessary for this purpose. If you fail to provide this information, your claim may be delayed or denied. You agree to authorize the Plan Manager's billing to other medical plans, for purposes of coordination of benefits.

Unless applicable law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under the Plan must provide any facts needed to pay the claim.

1. Applicability.

- a. This Coordination of Benefits (COB) provision applies to the Plan when a Subscriber or the subscriber's covered dependent has medical care coverage under more than one plan. "Plan" and "The Plan" are defined below.
- b. If this Coordination of Benefits provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of The Plan are determined before or after those of another plan. The benefits of The Plan:
 - (1) shall not be reduced when, under the order of benefit determination rules, benefits under The Plan are determined before another plan; but
 - (2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in paragraph 4. below.

2. Definitions.

- a. "**Plan**" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.
- b. "**The Plan**" is the part of the Plan that provides benefits for medical care expenses.
- c. "**Primary Plan/Secondary Plan**" The order of benefit determination rules state whether The Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When The Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When The Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, The Plan may be a Primary Plan as to one or more of the plans and may be a Secondary Plan as to a different plan or plans.

- d. **"Allowable Expense"** is a necessary, reasonable and customary item of expense for medical care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a primary plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, pre-certification of admissions or services, and preferred provider arrangements.

- e. **"Claim Determination Period"** is a calendar year. However, it does not include any part of a year during which a person has no coverage under The Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. Order of Benefit Determination Rules.

- a. **General.** When there is a basis for a claim under The Plan and another plan, The Plan is a Secondary Plan which has its benefits determined after those of another plan, unless:

- (1) the other plan has rules coordinating its benefits with those of The Plan; and
- (2) both those rules and The Plan's rules, in subparagraph b. below, require that The Plan's benefits be determined before those of the other plan.

- b. **Rules.** The order of benefits are determined using the first of the following rules which applies:

- (1) **Nondependent/Dependent.** The benefits of the plan which cover the person as a Covered Person or subscriber (that is, other than as a dependent) are determined before those of the plan which cover the person as a dependent.
- (2) **Dependent Child/Parents not Separated or Divorced.** Except as stated in subparagraph b. (3) below, when The Plan and another plan cover the same child as a dependent of different persons, called "parents":
 - (a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - (b) if both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- (3) **Dependent Child/Separated or Divorced.** If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - (a) first, the plan of the parent with custody of the child;
 - (b) then, the plan of the spouse of the parent with the custody of the child; and
 - (c) finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the medical care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- (4) **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for medical care expenses of the child, the plans covering the child follow the order of benefit determination rules outlined in subparagraph b. (2).
 - (5) **Active/Inactive Enrollee.** The benefits of a plan which covers a person as a Subscriber who is neither laid off nor retired (or as that Subscriber's dependent) are determined before those of a plan which cover that person as a laid off or retired Subscriber (or as that Subscriber's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - (6) **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered a Covered Person or subscriber longer are determined before those of the plan which covered that person for the shorter term.
- 4. **Effect on the Benefits of this Plan.**
 - a. **When this Section Applies.** This paragraph 4. applies when, in accordance with paragraph 3. "Order of Benefit Determination Rules", The Plan is a Secondary Plan as to one or more other plans. In that event the benefits of The Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in b. immediately below.
 - b. **Reduction in the Plan's Benefits.** The benefits of The Plan will be reduced when the sum of:
 - (1) the benefits that would be payable for the Allowable Expense under The Plan in the absence of this COB provision; and
 - (2) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of The Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of The Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of The Plan.
- 5. **Right to Receive and Release Needed Information.** Certain facts are needed to apply these COB rules. The Plan Manager has the right to decide which facts are needed. Consistent with applicable State and Federal law, the Plan Manager may get needed facts from or give them to any other organization or person, without your further approval or consent. Unless applicable Federal or State law prevents disclosure of the information without the consent of the patient or the patient's representative, each person claiming benefits under The Plan must give any facts the Plan Manager needs to pay the claim.
- 6. **Facility of Payment.** A payment made under another plan may include an amount which should have been paid under The Plan. If it does, the Plan Sponsor may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under The Plan. The Plan Sponsor will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.
- 7. **Right of Recovery.** If the amount of the payments made by the Plan Sponsor is more than the amount that should have paid under this COB provision, the Plan Manager may recover the excess from one or more of:
 - a. the persons it has paid or for whom it has paid;
 - b. insurance companies; or
 - c. other organizations.The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

The benefits provided by the Plan do not apply to injury or disease covered by no-fault insurance, employers liability laws (including workers' compensation), and care available or required to be furnished by or through national or State governments or their agencies including care to which a Covered Person is legally entitled and for which facilities are reasonably available for military service-connected conditions or disabilities. Subject to the Plan's rights in A. "Rights of

Reimbursement and Subrogation" above, medically necessary services will be provided upon request and only expenses incurred for medical treatment otherwise covered by the Plan will be paid if the no-fault insurer, employer, or national or State government or its agencies refuse to pay said expenses. You must cooperate with the Plan Manager's program to bill allowable no-fault and workers' compensation claims to the appropriate insurer(s).

C. MEDICARE AND THE PLAN

The provisions in this section apply to some, but not all, Covered Persons who are eligible for Medicare. They apply in situations where the Federal Medicare Secondary Payer Program allows Medicare to be the primary payer of a Covered Person's medical care claims. Consult your Employer to determine whether or not Medicare is primary in your situation.

Medicare is the primary payer for Covered Persons with end stage renal disease, after the 30 month period following the earlier of (1) the month in which the Covered Person begins a regular course of renal dialysis, or (2) the first of the month in which the Covered Person became entitled to Medicare, if the Covered Person received a kidney transplant without first beginning dialysis. This is regardless of the size of the Employer. Medicare is primary payer for retirees who are age 65 or over. Also, Medicare is a primary payer for Covered Persons under age 65, who are covered by Medicare because of disability (other than end stage renal disease), when (1) the Employer employs fewer than 100 employees and the Covered Person or their spouse or parent has group health plan coverage due to current employment, or (2) the Covered Person or their spouse or parent has coverage not due to current employment, regardless of the number of employees of the Employer.

Medicare is secondary payer for Medicare enrollees who: (1) are active employees and (2) are covered by Medicare because they have reached age 65 when there are 20 or more employees in the group. The Medicare secondary payer rules change from time to time and the most recent rule will be applied.

The benefits under the Plan are not intended to duplicate any benefits to which Covered Persons are, or would be, entitled under Medicare. All sums payable under Medicare for services provided pursuant to the Plan shall be payable to and retained by the Plan Sponsor. Each Covered Person shall complete and submit to the Plan such consents, releases, assignments and other documents as may be requested by the Plan Manager in order to obtain or assure reimbursement under Medicare for which Covered Persons are eligible.

The Plan also reserves the right to reduce benefits for any medical expenses covered under the Plan by the amount of any benefits available for such expenses under Medicare. This will be done before the benefits under the Plan are calculated. Charges for services used to satisfy a Covered Person's Medicare Part B deductible will be applied under the Plan in the order received by the Plan. Two or more charges for services received at the same time will be applied starting with the largest first.

The benefits under the Plan are considered secondary to those under Medicare if the Covered Person has actually enrolled in Medicare Part B.

The provisions of this section will apply to the maximum extent permitted by Federal or State law. The Plan will not reduce the benefits due any Covered Person due to that Covered Person's eligibility for Medicare where Federal law requires that the Plan determine the benefits for that Covered Person without regard to the benefits available under Medicare.

VII. CONTINUATION OF GROUP COVERAGE OR CONVERSION TO NON-GROUP COVERAGE

If your eligibility for group coverage under the Plan ends because of one of the qualifying events shown below, you may be eligible to continue group coverage as shown below.

A. CONTINUATION OF GROUP COVERAGE

1. **Qualifying Events.** Coverage under the Plan may be continued by a Subscriber, covered dependent spouse and other covered dependents, enrolled at the time coverage would otherwise end, or a child born to or placed for adoption with the Subscriber during the period of continuation coverage, as a result of one of the following qualifying events:
 - a. Termination of employment (except for gross misconduct) of the Subscriber, or reduction in hours resulting in a loss of group coverage.
 - b. Death of the Subscriber.
 - c. Divorce or legal separation of the Subscriber.
 - d. Loss of eligibility as a covered dependent child.
 - e. Initial enrollment of the Subscriber for Medicare.
 - f. For a retired Subscriber, spouse and other dependents, the bankruptcy filing by a former Employer, under Title XI, United States Code, on or after July 1, 1986.
2. **Duration of Continuation Coverage.** The maximum period coverage can be continued depends on the qualifying event. Continuation coverage may be terminated earlier as shown below. The maximum period of continuation coverage starts on the day of the qualifying event.
 - a. **Maximum period**
 - (1) **Termination and reduced hours.** The maximum period of continuation coverage is 18 months. If a second qualifying event, other than the Employer's bankruptcy, occurs during the 18 months, the maximum period of continuation coverage is 36 months. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
 - (2) **Disabled Subscriber, covered dependent spouse or covered dependent child.** If the Subscriber, covered dependent spouse or other covered dependent is disabled under Title II or XVI of the Social Security Act, at any time during the first 60 days of continuation of coverage, the 18-month maximum continuation period may be extended to 29 months. The disabled person must notify the Plan Sponsor within 60 days of the date of determination of disability, and within the initial 18-month continuation period. If a second qualifying event (other than bankruptcy) occurs during the extended 29-month period, the maximum period of continuation coverage is 36 months. See B. "Disabled Employee" below, which describes your rights for coverage as a disabled employee under Minnesota law.
 - (3) **Bankruptcy.** In the case of bankruptcy of a retired Subscriber's former Employer, the maximum period of continuation coverage is until the death of the retired Subscriber. In the case of the surviving spouse or dependent children of the retired Subscriber, the maximum period of continuation coverage is 36 months after the death of the retired Subscriber.
 - (4) **Divorce or legal separation.** Under Minnesota law, there is no maximum period of coverage for a former spouse or dependents who lose coverage due to divorce or legal separation. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
 - (5) **Death of Subscriber.** Under Minnesota law, there is no maximum period of coverage for a surviving spouse and dependents who lose coverage due to the death of the Subscriber. Coverage continues until the occurrence of one of the events shown in the paragraph "Earlier Termination".
 - (6) **Other qualifying events.** The maximum period of continuation coverage for all other qualifying events is 36 months.

b. **Earlier Termination**

Coverage terminates before the end of the maximum period if any of the following occurs.

- (1) **End of the Plan.** The Plan under which this coverage is offered to Subscribers is terminated.
- (2) **Failure to pay premium.** The person receiving continuation coverage does not make the monthly payment within 30 days of the due date.
- (3) **Other group health coverage.** The person receiving continuation coverage becomes covered under any other group health type coverage, not containing an exclusion or limitation for any pre-existing condition of the person. If the other group health coverage contains a pre-existing condition limitation, continuation coverage is extended until the pre-existing limitation is satisfied or coverage is otherwise terminated. A person will not be subject to earlier termination of continuation coverage on account of coverage under another group plan that existed prior to that person's first day of continuation coverage.
- (4) **Termination of extended coverage for disability.** In case a person receives extended (29-month) continuation coverage due to disability at the time of termination or reduced hours, the extended coverage terminates at the beginning of the month 30 days after a final determination that the person is no longer disabled. See B. "Disabled Employee" below, which describes your rights for coverage as a disabled employee under Minnesota law.
- (5) **Termination provisions of this Summary Plan Description.** The person's coverage is subject to termination under section I. of this Summary Plan Description.

3. **Election of Continuation Coverage**

- a. You have 60 days to elect continuation of group coverage. The 60-day period begins on the date your group coverage would otherwise terminate due to a qualifying event or the date on which written notice of your right of continued group coverage is mailed, whichever is later.
- b. If you wish to continue group coverage as shown above, you must apply in writing to your Employer (not the Plan). You must also pay your first monthly payment within 45 days of the date you elected to continue group coverage. If your coverage was terminated because of the death of the Subscriber, your initial payment is not due until 90 days after you receive notice of the continuation right. Thereafter, your monthly payments are due and payable at the beginning of each month for which coverage is to be continued.
- c. You or your covered dependents must notify the Plan Sponsor within 60 days, when divorce, legal separation, a change in status resulting in a loss of eligibility as a dependent would end coverage or a second qualifying event occurs. The 60-day period begins on the date of the divorce, legal separation, change in dependent status or second qualifying event.

4. **Procedures for Providing Notices Required Under This Continuation of Group Coverage Section**

- a. You must comply with the time limits for providing notices required in paragraph 3 (c) above.
- b. Your notice must be in writing and contain at least the following information:
 - (1) The names of the Subscriber and covered dependents;
 - (2) the qualifying event or disability; and
 - (3) the date on which the qualifying event (if any) occurred.

- c. Your notice must be sent to:

City of Duluth
402 City Hall
411 West First Street
Duluth, MN 55802

The Plan will comply with applicable Federal law for a Subscriber that is called to active military duty in the uniformed services.

B. DISABLED EMPLOYEE

The Plan Sponsor and the Plan agree not to terminate, suspend or otherwise restrict the participation in, or the receipt of, benefits otherwise payable hereunder, to any Subscriber who becomes totally disabled while employed by the Employer and covered hereunder while the Plan is in force, solely due to absence caused by such total disability. The Plan Sponsor may require the Subscriber to pay all or some part of the payment for coverage in this instance. Such payment shall be made to the Plan Sponsor by that Subscriber.

For the purpose of this section the term "total disability" means (1) the inability of an injured or ill Subscriber to engage in or perform the duties of the Subscriber's regular occupation or employment within the first two years of such disability and (2) after the first two years of such disability, the inability of the Subscriber to engage in any paid employment or work for which the Subscriber may, by education or training, including rehabilitative training, be or reasonably become qualified.

C. REPLACEMENT OF COVERAGE AND CONFINED COVERED PERSONS

When the Plan Sponsor replaces the Plan with that of another medical plan offering similar benefits, coverage will be extended for a Covered Person who is confined in an institution or institutions for medical care or treatment that would otherwise be covered under the Plan. Coverage will be extended only for services related to the condition for which the confinement is required. Coverage for these services will end on the earlier of the date of discharge or the date benefits provided under the Plan are exhausted.

D. PUBLIC EMPLOYEES

Certain retired employees of public or governmental entities and their dependents may be eligible for continued coverage upon retirement, pursuant to Minnesota Statute 471.61. If you qualify under this law, you may be required to pay the entire premium for continued coverage and will be required to notify your Employer within certain deadlines, of your intent to continue coverage.

E. CONVERSION TO NON-GROUP COVERAGE

1. **Eligibility for Conversion Coverage.** After a Covered Person has exhausted benefits under "Continuation of Group Coverage," he or she is eligible to apply for non-group conversion coverage of the type then in effect and available when application is made. This right to convert enables Covered Persons to enroll for health coverage without supplying evidence of good health. This right may be exercised by making application:
 - a. within 63 days of the date the Covered Person has exhausted his or her continuation right as described in part A. above.
 - b. within 63 days of the date of termination of a Covered Person's group coverage, if the Covered Person is not eligible for continuation under part A. above.If elected, conversion coverage takes effect on the date group coverage ceases or continuation eligibility terminates. The Covered Person must submit the required non-group enrollment prepayment along with an application to convert.

2. **Exception to the right to Conversion Coverage.** A Covered Person will not be allowed to convert to non-group conversion coverage if either of the following has occurred:
 - a. the Covered Person's group health plan sponsor replaces this Plan with another group health program prior to conversion or continues to offer other group health coverage; or
 - b. the Covered Person's coverage was ended for cause under I.K.

VIII. CLAIMS PROCEDURES

A. PROCEDURES FOR REIMBURSEMENT OF NETWORK SERVICES

When you present your identification card at the time of requesting network services from providers, paperwork and submission of claims relating to services will be handled for you by your provider. You may be asked by your provider to sign a form allowing your provider to submit the claim on your behalf. If you receive an invoice or bill from your provider for services, other than coinsurance, copayments or deductible amounts, simply return the bill or invoice to your provider, noting your enrollment in the Plan. Your provider will then submit the claim under the Plan. Your claim will be processed for payment according to the Employer's coverage guidelines.

B. PROCEDURES FOR REIMBURSEMENT OF SERVICES

1. **Claim Forms.** If claim forms are needed, please contact the Plan Manager at (952) 883-5000 or toll free at 1-800-883-2177. For hearing-impaired individuals, call (952) 883-5127 (TDD) or toll-free at 1-888-850-4762 (TDD). You must submit claims to the Plan Manager for out-of-network services on the claim form provided. Claim forms must include written proof which documents the date and type of service, provider name and charges, for which a claim is made.
2. **Proof of Loss.** Claims for services must be submitted to the Plan Manager at the address shown below. You must submit an itemized bill, which documents the date and type of service, provider name and charges, for the services incurred. Claims for services must be submitted within 90 days after the date services were first received for the injury or illness upon which the claim is based. Failure to file a claim within this period of time shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within that time. However, such claim must be filed as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than 15 months from the date services were first received for the injury or illness upon which the claim is based. If the Plan is discontinued or if HPAI ceases to act as the Plan Manager, the deadline for claim submission is 180 days. The Plan Manager may request that additional information be submitted, as needed, to make a claim determination.

Send itemized bills to: Claims Department
 HealthPartners, Inc.
 P.O. Box 1289
 Minneapolis, MN 55440-1289
3. **Time of Payment of Claims.** Benefits will be paid under the Plan within a reasonable time period.
4. **Payment of Claims.** Payment will be made according to the Plan Sponsor's coverage guidelines. All or any portion of any benefits for out-of-network services provided under the Plan on account of hospital, nursing, medical, or surgical services may, at the Plan Manager's option and, unless you request otherwise in writing not later than the time of filing the claim, be paid directly to the out-of-network provider rendering the services.
5. **Physical Examinations and Autopsy.** In the event the Plan Manager or Plan Sponsor requires information from a physical exam or autopsy to properly resolve a claim dispute, the Plan Manager or Plan Sponsor may request this information from you or your legal representative. Failure to submit the required information may result in denial of your claim.

6. **Clerical Error.** If a clerical error or other mistake occurs, that error does not deprive you of coverage for which you are otherwise eligible nor does it give you coverage under the Plan for which you are not eligible. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage. Determination of your coverage will be made at the time the claim is reviewed. It is your responsibility to confirm the accuracy of statements made by the Plan Sponsor or the Plan Manager, in accordance with the terms of this SPD and other Plan documents.

C. TIME OF NOTIFICATION TO CLAIMANT OF CLAIMS

The only claims under your Plan that meet the definition of “pre-service”, are those that require pre-certification by CareCheck®. For purposes of this claim and appeal process, all other claims, including requests for prior authorization, are considered “post-service” claims.

1. Pre-Service Claims (pre-certification requests).

When a request to CareCheck® for pre-certification for a non-urgent service is requested, an initial determination must be made within 15 calendar days. This time period may be extended for an additional 15 calendar days, provided that the Plan Manager determines that such extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

When a request to CareCheck® for pre-certification for an urgent service is requested, an initial determination must be made within 72 hours, so long as all information reasonably needed to make a decision has been provided. In the event that the claimant has not provided all information necessary to make a decision, the claimant will be notified of such failure within 24 hours. The claimant will then be given 48 hours to provide the requested information. The claimant will be notified of the benefit determination within 48 hours after the earlier of receipt of the complete information or the end of the time granted to the claimant to provide the specified additional information.

2. Post-Service Claims.

An initial determination of a claim for benefits must be made by HealthPartners within 30 days. This time period may be extended for an additional 15 days, provided that the Plan Manager determines that such an extension is necessary due to matters beyond the control of the Plan. If such extension is necessary, you will be notified prior to the expiration of the initial 30-day period.

You will receive written notification of any initial adverse claim determination as provided by applicable law.

D. CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR PRE-SERVICE CLAIMS

If your request to CareCheck® for pre-certification is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate. You must exhaust this appeal process prior to bringing a civil action. The steps in this appeal process are outlined below.

1. **First Level of Appeal to the Plan Manager.** You or your authorized representative must file your appeal within 180 days of the adverse decision. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

The Plan Manager will review your appeal and will notify you of its decision in accordance with the following timelines:

- If the claim being appealed is for urgent services, you may request an expedited appeal either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.
- If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

2. **Second Level of Appeal to the Plan Sponsor.** If after the first level of appeal your request was denied, you or your authorized representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Plan Sponsor and submit issues, comments and additional information as appropriate to:

City of Duluth
402 City Hall
411 West First Street
Duluth, MN 55802

- If the claim being appealed is for urgent services, you may request an expedited appeal either orally or in writing. Within 72 hours of such request, a decision on your appeal will be made.
- If the claim being appealed is for non-urgent services, a decision on your appeal will be made within 15 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

E. CLAIM DENIALS AND CLAIM APPEALS PROCESS FOR POST-SERVICE CLAIMS (all claims except requests from CareCheck® for pre-certification)

If your post-service claim for benefits under the Plan is wholly or partially denied, you are entitled to appeal that decision. Your Plan provides for two levels of appeal to the named fiduciary of your Plan or its delegate. You must exhaust both levels of appeal prior to bringing a civil action. The steps in this appeal process are outlined below.

1. **First Level of Appeal to the Plan Manager.** You or your authorized representative must file your appeal within 180 days of the adverse decision. Send your written request for review, including comments, documents, records and other information relating to the claim, the reasons you believe you are entitled to benefits, and any supporting documents to:

Member Services Department
HealthPartners, Inc.
8170 33rd Avenue South, P.O. Box 1309
Minneapolis, MN 55440-1309

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

The Plan Manager will review your appeal and will notify you of its decision within 30 days.

The time period may be extended if you agree.

All notifications described above will comply with applicable law.

2. **Second Level of Appeal to the Plan Sponsor.** If after the first level of appeal, your request was denied, you or your authorized representative may, within 180 days of the denial, submit a written appeal for review, including any relevant documents, to the Plan Sponsor and submit issues, comments and additional information as appropriate to:

City of Duluth
402 City Hall
411 West First Street
Duluth, MN 55802

The Plan Sponsor will review your appeal and will notify you of its decision within 30 days.

The time periods may be extended if you agree.

All notifications described above will comply with applicable law.

I have read the Summary Plan Description (draft #3 dated January 17, 2011), effective on January 1, 2011.

- ☒ **The Summary Plan Description is acceptable.**
- ☐ **The Summary Plan Description is acceptable with the attached revisions.** (Any revisions must be clearly indicated, initialed and dated and will be implemented to the Summary Plan Description prior to the final printing.)

Please send any revisions and the sign-off sheet to Chris Parrucci.

Kim G. Hall 1-18-11
Signature Date
City of Duluth Kim G. Hall
Manager of Human Resources, Healthcare & Safety

If you use **U.S. mail**, use the following address:

HealthPartners
Attn: Chris Parrucci, Sales/Marketing Department 21105M
P.O. Box 1309
Minneapolis, MN 55440-1309

If you use **overnight mail** or a **courier**, please use the following address:

HealthPartners
Attn: Chris Parrucci, Sales/Marketing Department 21105M
8170 33rd Avenue South
Bloomington, MN 55425

If you **fax** any pages with revisions and the sign-off sheet (faxed pages will expedite the process; however, we still need to receive the original sign-off sheet), use the following number:

(952) 853-8704

COMPREHENSIVE ENHANCED

utilizing the
Delta Dental PPO
and
Delta Dental Premier Networks

Dental Benefit Plan Summary

City of Duluth
Group Number 000405

DENTAL BENEFIT PLAN SUMMARY

This is a Summary of your Group Dental Program
(**PROGRAM**) prepared for Covered Persons with:

City of Duluth (**GROUP**), Airport, DECC and HRA

This Program has been established and is maintained and administered in accordance with the provisions of your Group Dental Plan Contract Number **000405** issued by Delta Dental of Minnesota (**PLAN**).

IMPORTANT

This booklet is subject to the provisions of the Group Dental Agreement and it cannot be modified in any way; nor shall you accrue any rights because of any statement in or omission from this booklet.

DELTA DENTAL OF MINNESOTA

Administrative Offices

P.O. Box 330
Minneapolis, Minnesota 55440-0330
(651) 406-5916 or (800) 553-9536
www.deltadentalmn.org

CITY OF DULUTH
DENTAL INSURANCE PLAN
EFFECTIVE JANUARY 1, 2006

Low Option Plan - \$1,000

<u>Group #</u>	<u>Group Name Requirements</u>	<u>Available Coverage</u>	<u>Effective Date</u>	<u>For Family</u>
000405-0006	Airport	Single, Single + Spouse, Single + Dependent Child, Single + 2 or More Dependents	1st of month following 6 months of eligible regular employment	2 Yrs In/ 2 Yrs Out
000405-0001	Basic	Single, Single + Spouse, Single + Dependent Child Single+ 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-0007	DECC	Single, Single + Spouse, Single + Dependent Child Single+ 2 or More Dependents	1st of month following 6 months of eligible regular employment	2 Yrs In/ 2 Yrs Out
000405-0003	Fire	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-0011	HRA	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following 6 months of eligible regular employment	2 Yrs In/ 2 Yrs Out
000405-0014	Legislative & Executive	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-0002	Police	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-0005	Supervisory	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-9272	COBRA Low Option (All)	Same as when employed	1st of month following term of benefits	N/A

Low Option - Confidential Unit Only - \$1,500

Group #	Group Name Requirements	Available Coverage	Effective Date	For Family
000405-0004	Confidential	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-9274	COBRA Low Option 1500	Same as when employed	1st of month following term of benefits	N/A

High Option Plan - \$2,000

Group #	Group Name Requirements	Available Coverage	Effective Date	For Family
000405-0015	Basic	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-0019	Confidential	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-0020	DECC	Single, Single + Spouse Single + Dependent Child Single + 2 or More Dependents	1st of month following 6 months of eligible regular employment	2 Yrs In/ 2 Yrs Out
000405-0013	Fire	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-0016	Legislative & Executive	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-0018	Police	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-0017	Supervisory	Single, Single + Spouse, Single + Dependent Child Single + 2 or More Dependents	1st of month following date of hire	2 Yrs In/ 2 Yrs Out
000405-9278	COBRA High Option (All)	Same as when employed	1st of month following term of benefits	N/A

PLAN ELIGIBILITY All regular full-time active employees of the City of Duluth working 37.5 hours or more per week are eligible as specified in the Plan. In addition, all Basic unit regular part-time employees working 24 - 30 hours per week and all Basic unit regular part-time employees working 14 - 23 ½ hours per week are eligible as specified in the Plan.

The following regular full-time active employees, appointed by the City of Duluth in the Legislative and Executive group, are eligible as specified in the Plan:
1) Attorneys; 2) Chief Administrative Officer; and 3) Mayor.

Eligible employees employed and defined by the following entities: DECC, HRA and Airport.

PLAN INELIGIBILITY Benefits will not be provided for expenses incurred while coverage is not in effect. Benefits will be paid for expenses covered under the Plan and will not be provided for expenses which are in excess of the contractual benefits provided. The Plan Document governs the amount of benefit payment and eligibility of individual members.

SOURCE OF CONTRIBUTIONS

The amount and source of contributions is determined by applicable bargaining agreements.

FUNDING MECHANISM: The program is funded by contributions to a self-insured fund as regulated by State Law.

When receiving care, present the identification card to whoever is rendering the services. If the provider of care has a contract with Delta Dental, the provider will submit the claim directly to the Claims Administrator. Delta Dental of Minnesota will then determine the benefits payable under the Plan and make the payment directly to the provider of services. The Provider will then bill you for any charges which are in excess of the contractual amount of services which are not eligible under the Plan.

If you have questions concerning a claim or the payment of a claim, they should be directed to:

Delta Dental of Minnesota
P.O. Box 330
Minneapolis, Minnesota 55440

Telephone inquiries can also be made by calling area code (651) 406-5916 or (800) 553-9536.

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SUMMARY OF DENTAL BENEFITS

After you have satisfied the deductible, if any, your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta is different for Delta Dental PPO dentists, Delta Dental Premier dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

Diagnostic and Preventive Service	100%
Basic Service	80%
Endodontics	80%
Periodontics	80%
Oral Surgery	80%
Major Restorative Services	80%
Prosthetic Repairs and Adjustments.....	80%
Prosthetics	50%

Covered persons will receive the maximum benefit when receiving dental care from a participating Delta Dental PPO provider. Increased benefits may also be provided for members receiving dental care from a Delta Dental Premier dentist. Members may seek dental services from a nonparticipating provider, however out-of-pocket expenses may increase.

Benefit Maximums

LOW OPTION:

The Program pays up to a maximum of \$1,000.00 (see pages ii of this benefit summary) for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

CONFIDENTIAL LOW OPTION:

The Program pays up to a maximum of \$1,500.00 (see page iii of this benefit summary) for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

HIGH OPTION:

The Program pays up to a maximum of \$2,000.00 (see page iii of this benefit summary) for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future coverage years.

Deductible

There is no deductible applicable to this plan.

Coverage Year

A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is January 1 to December 31.

DESCRIPTION OF COVERED PROCEDURES

Pretreatment Estimate (Estimate of Benefits)

IT IS RECOMMENDED THAT A PRETREATMENT ESTIMATE BE SUBMITTED TO THE PLAN PRIOR TO TREATMENT IF YOUR DENTAL TREATMENT INVOLVES MAJOR RESTORATIVE, PERIODONTICS OR PROSTHETIC CARE (SEE DESCRIPTION OF COVERAGES), TO ESTIMATE THE AMOUNT OF PAYMENT. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND THE PATIENT. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND THE PATIENT TO KNOW WHAT BENEFITS ARE AVAILABLE TO THE PATIENT BEFORE BEGINNING TREATMENT. THE PRETREATMENT ESTIMATE WILL OUTLINE THE PATIENT'S RESPONSIBILITY TO THE DENTIST WITH REGARD TO CO-PAYMENTS, DEDUCTIBLES AND NON-COVERED SERVICES AND ALLOWS THE DENTIST AND THE PATIENT TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENTS BEFORE TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED DELTA DENTAL PAYMENT IS BASED ON THE PATIENT'S CURRENT ELIGIBILITY AND CURRENT AVAILABLE CONTRACT BENEFITS. THE SUBSEQUENT SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN THE CONTRACT COVERAGE OR THE EXISTENCE OF OTHER COVERAGE MAY ALTER THE DELTA DENTAL FINAL PAYMENT AMOUNT AS SHOWN ON THE PRETREATMENT ESTIMATE FORM.

After the examination, your dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, periodontics or prosthetic care, a participating dentist should submit a claim form to the Plan outlining the proposed treatment.

A Pretreatment Estimate of Benefits statement will be sent to you and your dentist. You will be responsible for payment of any deductibles and coinsurance amounts or any dental treatment that is not considered a covered service under the Plan.

Benefits

The Program covers the following dental procedures when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Program shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under this Program, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Plan may require that a Covered Person be examined by a dental consultant retained by the Plan in or near the Covered Person's place of residence. The Plan shall hold such information and records confidential.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE DELTA DENTAL PREMIER NETWORK PRIOR TO RECEIVING DENTAL CARE.

Delta Dental of Minnesota does not determine whether a service submitted for payment or benefit under this Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. Delta Dental of Minnesota evaluates dental procedures submitted to determine if the procedure is a covered benefit under your dental plan. Your dental Plan includes a preset schedule of dental services that are eligible for benefit by the Plan. Other

dental services may be recommended or prescribed by your dentist, which are dentally necessary, offer you an enhanced cosmetic appearance, or are more frequent than covered by the Plan. While these services may be prescribed by your dentist and are dentally necessary for you, they may not be a dental service that is benefited by this Plan or they may be a service where the Plan provides a payment allowance for a service that is considered to be optional treatment. If the Plan gives you a payment allowance for optional treatment that is covered by the plan, you may apply this Plan payment to the service prescribed by your dentist which you elected to receive. Services that are not covered by the Plan or exceed the frequency of Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Plan. Determination of services necessary to meet your individual dental needs is between you and your dentist.

ONLY those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below. For estimates of covered services, please see the "Pretreatment Estimate" section of this booklet.

PREVENTIVE CARE (Diagnostic & Preventive Services)

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per calendar year limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per calendar year limitation.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of bitewings per 12-month period.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 36-month period.
- **Periapical(s)** - Single X-rays.
- **Occlusal** - Covered at 1 series per 12-month period.

Dental Cleaning

- **Prophylaxis or Periodontal Maintenance** - Any combination of these procedures is covered 2 times per calendar year.

Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

NOTE: A prophylaxis performed on a Covered Person under the age of 14 will be benefited as a child prophylaxis. A prophylaxis performed on a Covered Person age 14 or older will be benefited as an adult prophylaxis.

Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment (Topical application of fluoride) - Covered 1 time per 12-month period for dependent children up to the age of 19.

Oral Hygiene Instructions - Instructions which include tooth-brushing techniques, flossing and use of oral hygiene aids are covered 1 time per lifetime.

Space Maintainers - Covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances is not a covered benefit.

BASIC SERVICES

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior teeth.
- **Posterior (back) Teeth** - This service is not covered under Basic Services. Refer to the Complex or Major Restorative Services section of your benefits.

LIMITATION: Coverage for amalgam or composite restorations will be limited to only 1 service per tooth surface per 24-month period.

Other Basic Services

- **Restorative cast post and core build-up, including pins and posts** - See benefit coverage description under Complex or Major Restorative Services.
- **Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 24-month period for eligible dependent children through the age of 18.
- **Sealants** - Covered 1 time per lifetime for permanent first and second molars of eligible dependent children through the age of 15.

Adjunctive General Services

- **Intravenous Conscious Sedation and IV Sedation** - Covered when performed in conjunction with complex surgical service.

LIMITATION: Intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

EXCLUSIONS - Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouth guard, enamel microabrasion, and odontoplasty.

4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents, tooth bonding and veneers.
5. Placement or removal of sedative filling, base or liner used under a restoration.

BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**
- **Apicoectomy**
- **Root Amputation on posterior (back) teeth**

Complex or other Endodontic Services

- **Apexification** - For dependent children through the age of 16.
- **Retrograde filling**
- **Hemisection, includes root removal**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.

PERIODONTICS (GUM & BONE TREATMENT)

Basic Non Surgical Periodontal Care - Treatment for diseases for the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planning** - Covered 1 time per 24 months.
- **Full mouth debridement** - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this plan.

- **Gingivectomy/gingivoplasty**
- **Gingival curettage**
- **Gingival flap**
- **Apically positioned flap**
- **Mucogingival surgery**
- **Osseous surgery**

- **Bone replacement graft**
- **Pedicle soft tissue graft**
- **Free soft tissue graft**
- **Subepithelial connective tissue graft**
- **Soft tissue allograft**
- **Combined connective tissue and double pedicle graft**
- **Distal/proximal wedge**

LIMITATION: Only 1 complex surgical periodontal service is a benefit covered 1 time per 36-month period per single tooth or multiple teeth in the same quadrant.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

ORAL SURGERY (TOOTH, TISSUE, OR BONE REMOVAL)

Basic Extractions

- Removal of Coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Oroantral fistula closure
- Tooth reimplantation - accidentally evulsed or displaced tooth
- Surgical exposure of impacted or unerupted tooth to aid eruption
- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal of nonodontogenic or odontogenic cyst or tumor
- Removal of exostosis
- Partial ostectomy

- Incision & drainage of abscess
- Frenulectomy (frenectomy or frenotomy)

Temporomandibular Joint Disorder (TMJ) as covered under Minnesota Statutes Section 62A.043 Subd. 3 -

Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre-treatment Estimate of Benefits is recommended.

NOTE: If you or your dependents currently have medical insurance coverage, the claim must first be submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see Coordination of Benefits). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to this Plan.

If you or your dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this dental Plan within the noted Plan limitations, maximums, deductibles and payment percentages of treatment costs.

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by Minnesota Statute 62A.25 provided, however, that such procedures are dental reconstructive surgical procedures.
2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statute section 62A.042.

For programs without orthodontic coverage: Dental orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit plan.

For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.
2. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
5. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
6. Surgical repositioning of teeth.
7. Inpatient or outpatient hospital expenses.

8. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.

COMPLEX OR MAJOR RESTORATIVE SERVICES

Services performed to restore lost tooth structure as a result of decay or fracture

Posterior (back) Teeth Composite (white) Resin Restorations

- If the posterior (back) tooth requires a restoration due to decay or fracture;
- If no other posterior (back) composite (white) resin restoration for the same or additional tooth surface(s) was performed within the last 24 months.

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Inlays - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Onlays - Covered 1 time per 5-year period per tooth.

Permanent Crowns - Covered 1 time per 5-year period per tooth.

Implant Crowns - See Prosthetic Services.

Crown Repair - Covered 1 time per 12-month period per tooth.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 5-year period when done in conjunction with covered services.

Canal prep & fitting of preformed dowel & post

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Temporary, provisional or interim crown.
6. Occlusal procedures including occlusal guard and adjustments.

PROSTHETIC SERVICES (DENTURES, PARTIALS, AND BRIDGES)

Reline, Rebase, Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s)

- Covered when:

- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Adjustments - Covered 2 times per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 5-year period:

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials and Dentures) - A restoration that is retained, supported and stabilized by an implant. Implants and related services are NOT covered.

LIMITATION: This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility. For example: A single crown to restore one open space will be given the benefit of a Fixed Partial Denture Pontic (one unit). The optional benefit is subject to all contract limitations on the benefited service.

Restorative cast post and core build-up, including pins and posts - Covered 1 time per 5-year period when done in conjunction with covered fixed prosthetic services.

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
3. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
4. Additional, elective or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
5. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.

6. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
7. Services or supplies that have the primary purpose of improving the appearance of your teeth.
8. Placement or removal of sedative filling, base or liner used under a restoration.
9. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
10. Coverage shall be limited to the least expensive professionally acceptable treatment.

Exclusions

Coverage is NOT provided for:

- a) Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.
- b) Dental services or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- c) New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.
- d) Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.
- e) Dental services completed prior to the date the Covered Person became eligible for coverage.
- f) Services of anesthesiologists.
- g) Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
- h) Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
- i) Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
- j) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- k) Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants.
- l) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

- m) Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.
- n) Case presentations, office visits and consultations.
- o) Incomplete, interim or temporary services.
- p) Athletic mouth guards, enamel microabrasion and odontoplasty.
- q) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
- r) Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
- s) Bacteriologic tests.
- t) Cytology sample collection.
- u) Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.
- v) Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- w) Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
- x) The replacement of an existing partial denture with a bridge.
- y) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- z) Provisional splinting, temporary procedures or interim stabilization.
- aa) Placement or removal of sedative filling, base or liner used under a restoration.
- bb) Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- cc) Occlusal procedures including occlusal guard and adjustments.

Limitations

- a) **Optional Treatment Plans:** in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.
- b) **Reconstructive Surgery:** benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by MN Statute 62A.25 provided, however, that such services are dental reconstructive surgical services.
- c) **Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statutes Section 62A.042.** For Programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For Programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.

For other dental procedure exclusions and limitations, refer to the Description of Coverage in this Dental Benefit Plan Summary.

Post Payment Review

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 - Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed are subject to recovery. Delta Dental's right to conduct post payment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

Optional Treatment Plans

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

ELIGIBILITY

Covered Persons under this Program are:

Employees

- a) All eligible employees who have met the eligibility requirements as established by the Group and stated within this Dental Benefit Plan Summary under Effective Date of Coverage.
- b) Employees on Family and Medical Leave as mandated by the Federal FMLA.

Retirees

Retirees who are entitled to participate in the City of Duluth Retiree Medical Plan and their eligible dependents may continue dental coverage provided that, at the time of retirement, this Program remains in effect and you or your spouse or your eligible dependent child is a Covered Person under this Program. Retirees may elect to drop their spouse and/or eligible dependent(s) from the Plan, but may not request to add coverage for their spouse and/or eligible dependent(s) upon commencement of Retiree dental coverage.

Dependents

- a) Spouse, meaning: Married; Legally Separated
- b) Unmarried dependent children to age 25, including:
 - Natural-born and legally adopted children
 - Stepchildren who reside with you
 - Children who are required to be covered by reason of a Qualified Medical Child Support Order
- c) Children who become handicapped prior to reaching the Plan's limiting age if:
 - They are primarily dependent upon you; and
 - Are incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or mental disorders

The dependents of an eligible, covered City employee (Basic, Confidential, Fire, Legislative and Executive, Police or Supervisory groups) may participate in the City dental care plan under the following conditions:

- (a) The eligible employee may make written application for his/her dependents within thirty-one (31) days of becoming eligible. Coverage will begin on the day the dependent becomes eligible (as defined by the Life Qualifying Events listed below).

NOTE: See pages ii and iii

Life Qualifying Events:

The City of Duluth's policy changed effective January 1, 1997 and now allows *active and retired* employees to participate in benefit changes when their life changes, providing the change is made within thirty-one (31) days of the event on appropriate paperwork through Employee Benefits. This could involve adding or deleting dependents to our dental plan.

The life qualifying events recognized by the City (due to an arbitration award) are:

- Adoption of child;
- Birth of a child;
- Death of an employee or family member;
- Divorce;
- Employee change in employment status;
- Marriage;
- Open Enrollment (either regular or mid-year in event of a contract settlement offering substantial changes in benefits);
- Retirement;
- Spouse change in employment, or;
- Unpaid Leave of Absence taken by employee or spouse (exceeds leave of absence covered under FMLA)

If you experience one of the Life Qualifying Events during the plan year, you have 31 days (except in the case of the birth/adoption of a child - see Effective Dates of Coverage) from the event to change your current election. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next Open Enrollment period. You may obtain the appropriate paperwork by contacting the City of Duluth Human Resources Department. All changes are effective the date of the change. If you have a life qualifying event and wish to change your coverage, you will need to:

1. Notify the Human Resources Department of any life qualifying events.
2. Complete the appropriate paperwork to change your coverage and payroll deduction.
3. Return paperwork along with any required documentation supporting the Life Qualifying Event to the Human Resources Department.

With retirement being recognized as a Life Qualifying Event a retiree may add or delete spouse and eligible dependents within thirty-one (31) days of retirement. However, once a spouse and/or eligible dependent is dropped by the retiree from his or her coverage, the retiree may not later add a spouse or any eligible dependent(s) to his or her dental coverage. Additionally, once a retiree drops his or her dental coverage, he/she may not re-enroll in the City of Duluth dental plan at a later date.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have a baby, it is consistent to add

your newborn to your current dental coverage but it not consistent to drop your dental coverage altogether.

- (b) The eligible employee electing dependent coverage pays to the City or its designee, promptly when due, either directly or through payroll deduction, the full cost of participation in the dental care plan.
- (c) The employer is financially and legally able to maintain a group dental health care indemnity plan.
- (d) The eligible dependents must continue to participate in, and pay the full cost of, the plan unless the eligible employee ceases to be represented by the employee bargaining unit, or the eligible dependent dies, ceases to be an eligible dependent, or the marriage is terminated.

NOTE: If you, your spouse and/or dependent child(ren) are employees of the Employer (i.e., City of Duluth), you may be covered as either an employee or as a dependent, but not both. Additionally, your eligible dependent children may be covered under either parent's coverage, but not both. At no time will an employee or dependent be covered more than once under the Plan.

Effective Dates of Coverage

Eligible Employee:

In accordance with the Plan Eligibility definition stated on page iv, you are covered under this Plan when the program first became effective, August 1, 1988 or if you are new City of Duluth Group employee:

1. First of the month following the date of regular hire for employees in the Basic, Confidential, Fire, Police, Supervisory and Legislative & Executive Groups; and
2. First of the month following 6 months of eligible regular employment for employees in the Airport, DECC and HRA Groups.

Eligible Dependents:

Your eligible dependents, as defined, are covered under this Program:

1. On the date you 1st become eligible for coverage, if dependent coverage is provided or elected.
2. On the date you first acquire eligible dependents, or add dependent coverage subject to the "Normal" or "Midyear" open enrollment requirements, if any.
3. On the date a new dependent is acquired if you experience a Life Qualifying Event and make proper application for coverage within 31 days (see page 13 for Life Qualifying Events).

Children may be added to the Program at the time the eligible employee originally becomes effective or may be added anytime up to 30 days following the child's 3rd birthday. If a child is born or adopted after the employee's original effective date, such child may be added anytime between birth (or date of adoption) and 30 days following the child's 3rd birthday. In the event that the child is not added by 30 days following their 3rd birthday, that child may be added only if there is a Family Status Change or at the next Open Enrollment period, if any.

The eligibility of all Covered Persons, for the purposes of receiving benefits under the Program, shall, at all times, be contingent upon the applicable monthly payment having been made for such Covered Person by the Group on a current basis.

Open Enrollment - Normal

The Open Enrollment under this Contract shall be held annually, with all changes becoming effective January 1st of the following year. This is the time certain employees may make changes to their dental insurance; adding or deleting dependents, unless it is not specified above.

Open Enrollment - Midyear

Labor contracts are renegotiated continually and are mostly two (2) year contracts. Sometimes the contracts may not settle until a year or two (2) after the commencement date of the new contract. When a contract is settled that involves substantially changing the pay or benefits, a mid-year Open Enrollment is necessary. The effective date of any changes is the first of the month following the signing of the contract unless the date is specified in the labor contract. There is no specific date or month a contract may settle and the Employer has the right to determine whether the contract entitles the employees to an additional Open Enrollment period.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the earliest of the following dates:

- a) The end of the month in which (1) you cease to be eligible; (2) your dependent is no longer eligible as a dependent under the Program.
- b) On the date the Program is terminated.
- c) On the date the Group terminates the Program by failure to pay the required Group Subscriber payments, except as a result of inadvertent error.

For extended eligibility, see Continuation of Coverage.

The Group or Plan Sponsor reserves the right to terminate the Plan, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the Plan will result in loss of benefits for all covered persons. If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination.

Continuation of Coverage (COBRA)

Dental benefits may be continued should any of the following events occur, provided that at the time of occurrence this Program remains in effect and you or your spouse or your dependent child is a Covered Person under this Program:

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, leave of absence, lay-off, or employee becomes ineligible (except gross misconduct dismissal)	Employee and dependents	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage or Medicare
Divorce, marriage dissolution, or legal separation	Former Spouse and any dependent children who lose coverage	Earliest of: 1. Enrollment date in other group coverage, or 2. Date coverage would otherwise terminate.
Death of Employee	Surviving spouse and dependent children	Earliest of: 1. Enrollment date in other group coverage, or 2. Date coverage would have otherwise terminated under the contract had the employee lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or Medicare

		or 3. Date coverage would otherwise end.
Dependents lose eligibility due to Employee's entitlement to Medicare	Spouse and dependents	Earliest of: 1. 36 months, 2. Enrollment date in other group coverage, or 3. Date coverage would otherwise end.
Employee's total disability	Employee and dependents	Earliest of: 1. Date total disability ends, or 2. Date coverage would otherwise end.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and dependents	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or dependent electing COBRA.
Surviving Dependents of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving Spouse and dependents	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.
Those retirees eligible under the terms set forth in Chapter 471.61 Subd.2b legislation	Retiree and dependents	Maximum continuation period: 1. Indefinitely, as allowed by law.

You or your eligible dependents have 60 days from the date you lose coverage, due to one of the events described above, to inform the Group that you wish to continue coverage; except that, in the case of death of an eligible employee, such notification period to continue coverage shall be 90 days.

1. Choosing Continuation

If you lose coverage, your employer must notify you of the option to continue coverage within 10 days after employment ends. If coverage for your dependent ends because of divorce, legal separation, or any other change in dependent status, you or your covered dependents must notify your employer within 60 days.

You or your covered dependents must choose to continue coverage by notifying the employer in writing. You or your covered dependents have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered dependents ineligible to choose continuation at a later date. You or your covered dependents have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered dependents must pay charges monthly in advance to the employer to maintain coverage in force.

Charges for continuation are the group rate plus a two percent administration fee. All charges are paid directly to your employer. If you or your covered dependents are totally disabled, charges for continuation are the group rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer may charge the group rate plus a 50 percent administration fee.

2. Second qualifying event

If a second qualifying event occurs during continuation, a dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

When a second qualifying event occurs such as the death of the former covered employee, the dependent must notify the employer of the second event within 30 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

A qualified beneficiary is any individual covered under the health plan the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

3. Terminating Continuation of Coverage - COBRA

Continuation of Coverage - COBRA for you and your eligible dependents, if selected, shall terminate on the last day of the month in which any of the following events first occur:

- a) The expiration of the specified period of time for which Continuation of Coverage - COBRA can be maintained; as mandated by applicable State or Federal law;
- b) This Program is terminated by the Group Subscriber;
- c) The Group Subscriber's or Covered Person's failure to make the payment for the Covered Person's Continuation of Coverage

Questions regarding Continuation of Coverage - COBRA should be directed to your employer. Your employer will explain the regulations, qualifications and procedures required when you continue coverage.

PLAN PAYMENTS

Participating Dentist Network

A Delta Dental Premier dentist is a dentist who has signed a participating and membership agreement with his/her local Delta Dental Plan. The dentist has agreed to accept Delta Dental's Maximum Amount Payable as payment in full for covered dental care. Delta Dental's Maximum Amount Payable is a schedule of fixed dollar maximums established solely by Delta Dental for dental services provided by a licensed dentist who is a participating dentist. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental Premier dentist has agreed not to bill more than Delta Dental's allowable charge. A Delta Dental Premier dentist has also agreed to file the claim directly with Delta Dental.

A Delta Dental PPO network dentist is a dentist who has signed Delta Dental PPO agreement with Delta Dental of Minnesota. The dentist has agreed to accept the Delta Dental PPO Maximum Amount Payable as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental PPO dentist has agreed not to bill more than the Delta Dental PPO Maximum Amount Payable. A Delta Dental PPO dentist has also agreed to file the claim directly with Delta Dental.

Names of Participating Dentists can be obtained, upon request, by calling Delta, or from the Plan's internet web site at www.deltadentalmn.org. Refer to the General Information section of this booklet for detailed information on how to locate a participating provider using the Plan's internet web site.

Covered Fees

Under this Program, YOU ARE FREE TO GO TO THE DENTIST OF YOUR CHOICE. You may have additional out-of-pocket costs if your dentist is not a participating Delta Dental PPO or Delta Dental Premier dentist with the plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta. This payment difference could result in some financial liability to you. The amount is dependent on the nonparticipating dentist's charges in relation to the Table of Allowances determined by Delta.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE DELTA DENTAL PPO AND DELTA DENTAL PREMIER NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Claim Payments

PAYMENTS ARE MADE BY THE PLAN ONLY WHEN THE COVERED DENTAL PROCEDURES HAVE BEEN COMPLETED. THE PLAN MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR PROVIDER BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, THE PLAN MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

ANY BENEFITS PAYABLE UNDER THIS PLAN ARE NOT ASSIGNABLE BY ANY COVERED PERSON OR ANY ELIGIBLE DEPENDENT OF ANY COVERED PERSON.

Delta Dental Premier Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental Premier dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental Premier dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Delta Dental PPO Dentists:

Claim payments are based on the Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO dentist to a Delta Dental covered patient. The Plan Payment Obligation for Delta Dental PPO dentists is the lesser of: (1) The fee pre-filed by the dentist with their Delta Dental organization; (2) The Delta Dental PPO Maximum Amount Payable as determined by Delta Dental; (3) The fee charged or accepted as payment in full by the Delta Dental PPO dentist regardless of the amount charged. All Plan Payment Obligations are determined prior to the calculation of any patient co-payments and deductibles as provided under the patient's Delta Dental program.

Nonparticipating Dentists:

Claim payments are based on the Plan's Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the Table of Allowances established solely by Delta Dental, whichever is less. The Table of Allowances is a schedule of fixed dollar maximums established by Delta

Dental for services rendered by a licensed dentist who is a nonparticipating dentist. Claim payments are sent directly to the Covered Person.

THE COVERED PERSON IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY THE NONPARTICIPATING DENTIST. WHEN SERVICES ARE OBTAINED FROM A NONPARTICIPATING PROVIDER, ANY BENEFITS PAYABLE UNDER THE GROUP CONTRACT ARE PAID DIRECTLY TO THE COVERED PERSON.

Coordination of Benefits (COB)

If you or your dependents are eligible for dental benefits under this Program and under another dental program, benefits will be coordinated so that no more than 100% of the Plan Payment Obligation is paid jointly by the programs. The Plan Payment Obligation is determined prior to calculating all percentages, deductibles and benefit maximums.

The Coordination of Benefits provision determines which program has the primary responsibility for providing the first payment on a claim. In establishing the order, the program covering the patient as an employee has the primary responsibility for providing benefits before the program covering the patient as a dependent. If the patient is a dependent child, the program with the parent whose month and day of birth falls earlier in the calendar year has the primary payment responsibility. If both parents should have the same birth date, the program in effect the longest has the primary payment responsibility. If the other program does not have a Coordination of Benefits provision, that program most generally has the primary payment responsibility.

NOTE: When Coordination of Benefits applies for dependent children, provide your dentist with the birth dates of both parents.

Claim and Appeal Procedures

Initial Claim Determinations

All claims should be submitted within 12 months of the date of service. An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and you will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

Appeals

In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your appeal. Send your appeal to:

Delta Dental of Minnesota
Attention: Appeals Unit
PO Box 551
Minneapolis, MN 55440-0551

Your appeal must include your name, your identification number, group number, claim number, and dentist's name as shown on the Explanation of Benefits. Send your appeal to the address shown on the Explanation of Benefits.

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the

denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of dental services eligible under your plan, claims are not reviewed to determine dental necessity or appropriateness. In all cases where professional judgment is required to determine if a procedure is covered under your plan's schedule of benefits, we will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any dental professional whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. However, no authorization is required for your treating dentist to make a claim or appeal on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling Customer Service. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

GENERAL INFORMATION

Health Plan Issuer Involvement

FOR SELF-FUNDED: The benefits under the Plan are not guaranteed by Delta under the Contract. As Claims Administrator, Delta pays or denies claims on behalf of the Plan and reviews requests for review of claims as described in the Claim and Appeals Procedures section.

Privacy Notice

Delta Dental of Minnesota will not disclose non-public personal financial or health information concerning persons covered under our dental benefit plans to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under our dental benefit plans.

How to Find a Participating Dentist

A real-time listing of participating dentists is available in an interactive directory at the Plan's user friendly web site, www.deltadentalmn.org. The Plan highly recommends use of the web site for the most accurate network information. Go to <http://www.deltadentalmn.org/dentist/search.asp> and enter your zip code, city or state to find local participating dentists. You can also search by dentist or clinic name. The Web site also allows you to print out a map directing you to the dental office you select. **The Dentist Search is an accurate and up-to-date way to obtain information on participating dentists.**

To search for and verify the status of participating providers, select "Dentist Search" on the www.deltadentalmn.org home page. Select the Product or Network in the drop-down menu, and search by city and state, zip code or provider or clinic name. If your dentist does not participate in the network, you may continue to use that dentist, although you will share more of the cost of your care and could be responsible for dental charges up to the dentist's full billed amount.

If you do not have Internet access, other options are available to find a network dentist or verify that your current dentist is in the network.

- When you call to make a dental appointment, always verify the dentist is a participating dentist. **Be sure to specifically state that your employer is providing the Dental program.**
- Contact our Customer Service Center at: (651) 406-5916 or (800) 553-9536. Customer Service hours are 7 a.m. to 7 p.m., Monday through Friday, Central Standard Time.

Using Your Dental Program

Dentists who participate with Delta under this Program are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service.

If your dentist is a participating dentist, the claim form will be available at the dentist's office.

If your dentist is nonparticipating, claim forms are available by calling:

Delta Dental of Minnesota - (651) 406-5916 or (800) 553-9536

The Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

- * YOUR DELTA GROUP NUMBER
- * YOUR EMPLOYER (GROUP NAME)
- * YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** Identification number)
- * YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

Cancellation and Renewal

The Program may be canceled by the Plan only on an anniversary date of the Group Dental Plan Contract, or at any time the Group fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Program, Covered Persons of the Group have no right to continue coverage under the Program or convert to an individual dental coverage contract.

DELTA DENTAL OF MINNESOTA

FOR CLAIMS AND ELIGIBILITY

P.O. Box 330
Minneapolis, Minnesota 55440-0330
(651) 406-5916 or (800) 553-9536

FOR APPEALS

P.O. Box 551
Minneapolis, Minnesota 55440-0551

CORPORATE LOCATION

3560 Delta Dental Drive
Eagan, Minnesota 55122-3166
(651) 406-5900 or (800) 328-1188
www.deltadentalmn.org

CORPORATE MAILING ADDRESS

P.O. Box 9304
Minneapolis, Minnesota 55440-9304
(651) 406-5900 or (800) 328-1188

Updated 7/2009
Printed 11/2006 (300 copies)

BYLAWS OF THE JOINT POWERS ENTERPRISE

ARTICLE I. ESTABLISHMENT.

Section 1. Joint Powers Agreement. A Joint Powers Agreement (the "Agreement"), authorized under and described in Section 471.59 of the Minnesota Statutes, creating the Joint Powers Enterprise was entered effective March 31, 2011, by and among the City of Duluth, the Duluth Airport Authority, the Duluth Entertainment and Convention Center, and the Duluth Housing and Redevelopment Authority (collectively referred to herein as the "Members"). The Agreement reflects the creation of a Joint Powers Enterprise through which the Members' jointly sponsor and maintain one or more employee benefit plans (the "Plan(s)") and operate a joint-self insurance pool (the "Pool"). The existence of certain Plans and the Pool pre-date the effective date of the Agreement and these Bylaws, as further described in the Agreement.

Section 2. Defined Terms. Terms appearing in initial capital letters that are not otherwise defined within these Bylaws are defined in the Joint Powers Agreement creating the Joint Powers Enterprise.

Section 3. Board. The Agreement establishes a Board of Trustees (the "Board") with certain powers of oversight and direction of the Joint Powers Enterprise, including the Plan(s) and the Pool.

Section 4. Bylaws. These Bylaws have been originally adopted by the initial Members to supplement the Agreement and to describe the purpose, governance, and administration of Joint Powers Enterprise established by the Agreement. These Bylaws, combined with the Agreement, are intended to satisfy the requirements of applicable law, including Section 471.617 of the Minnesota Statutes and Chapter 2785

Including Section 2785.0400 of the Minnesota Rules as they relate to the Pool. These Bylaws may be amended or restated as described later in this Agreement.

ARTICLE II. PURPOSE.

The purposes of the Joint Powers Enterprise, Including the Pool, are described in the Introduction to the Agreement and in Article I of the Agreement.

ARTICLE III. BOARD.

To the extent not addressed in the Agreement, the operation of the Board is subject to the following requirements:

Section 1. Disqualification. A Representative shall be disqualified from serving as a Representative of the Board if such Representative is no longer employed by the Member he/she represents.

Section 2. Committees. The Board may from time to time, by resolution, authorize and establish advisory committees, as described in the Agreement, having the authority and responsibilities provided in the authorizing resolution. Any committee so established shall consist of two or more natural persons only one of which needs to be a Representative, and shall be subject at all times to the direction and control of the Board. At any meeting of such committee the presence of a majority of the natural persons assigned to the committee shall be necessary to constitute a quorum for the transaction of business. Committees shall act by an affirmative majority vote of those present at a duly held meeting, except where the affirmative vote of a larger proportion or number is required by the Board. If permitted by applicable law, any action required or permitted to be taken at a committee meeting may be taken by a written action signed collectively, or individually in counterparts, by all natural persons assigned to

such committee. Each committee shall keep a written record of its activities and shall submit such written record to the Board after each meeting.

Section 3. Officers.

- (a) Number. The officers of the Board, who shall be one or more natural persons, shall consist of a Chairperson, Secretary and a Treasurer, and may consist of such other officers as the Board may designate from time to time. All officers must be Representatives on the Board. A Representative may simultaneously hold more than one office.
- (b) Election and Term of Office. The Chairperson shall be appointed as provided in the Agreement. The other officers shall be elected or appointed periodically by the Board. Each officer, other than the Chairperson, shall hold office for a period of two (2) years, or until their respective successors are duly elected, or until their earlier death, resignation or removal.
- (c) Resignation. Any officer may resign at any time by giving written notice of resignation to the Board or to the Chairperson. A resignation shall take effect at the later of the time specified in the written notice or the time the written notice is received. The acceptance of a resignation shall not be necessary to make it effective.
- (d) Removal. Any officer, other than the Chairperson, may be removed, with or without cause, by a two-thirds vote in favor of the removal, taken at a meeting of the Board called for the purpose of voting on the removal. The purpose of the meeting shall be stated in the notice of the meeting.

- (e) Temporary Vacancy. A temporary vacancy in any office (other than the office of the Chair), because of a disability shall be filled by a majority vote of the Representatives. There is no requirement that the Representative taking the vacated officer's place automatically assume an office held by that person. An officer elected to fill a temporary vacancy shall serve until the earlier of (1) the point at which the vacated officer is no longer disabled, (2) the point at which the Representative is no longer a Representative, or (3) the end of the unexpired term of the vacated officer. .
- (f) Permanent Vacancy. A permanent vacancy in any office (other than the office of the Chair), because of death, resignation, or removal shall be filled by a majority vote of the Representatives. There is no requirement that the Representative taking the vacated officer's place automatically assume an office held by that person. An officer elected to fill a permanent vacancy shall serve until the earlier of (1) the point at which the Representative is no longer a Representative, or (2) for the unexpired term of the predecessor in office.
- (g) Chairperson. The Chairperson shall: (a) when present, preside at all meetings of the Representatives; (b) see that all orders and resolutions of the Board are carried into effect; (c) execute and deliver in the name of the Board (except in cases in which such execution and delivery shall be expressly delegated to some other officer or agent of the Board or shall be required by law to be otherwise executed and delivered) any contracts,

reports, or other instruments pertaining to the business of the Board, including, without limitation, any instruments necessary or appropriate to enable the Board to act in furtherance of the purposes of this organization as described in these Bylaws; (d) maintain records of and, when necessary, certify proceedings of the Board; and (e) perform such other duties as may from time to time be prescribed by the Board.

(h) Secretary. The Secretary shall make, or arrange to have made, and keep all records of the Board, shall attend to the giving and serving of all notices of the Board, and shall perform such other duties as may be required by the Board.

(i) Treasurer. The Treasurer of the Board shall: (a) keep accurate accounts of all moneys the Board receives or disburses, if any; (b) deposit all moneys, drafts, and checks in the name of, and to the credit of, the Joint Powers Enterprise, Including the Plan(s) and Pool, in such banks and depositories as the Board shall from time to time designate; (c) have power to endorse for deposit all notes, checks, and drafts received by this organization; (d) disburse the funds of this organization as ordered by the Board, making proper vouchers therefor; (e) render to the Chairperson and the Representatives, whenever requested, an account of all the transactions and of the financial condition of the Board; and, (f) in general, perform all duties usually incident to the office of the Treasurer.

ARTICLE IV. SELECTION OF SERVICE PROVIDERS

Section 1. Administrative Services Company. The Board shall select one or more service company(ies) using a "request for proposal" process determined by the

Board. The Board, on behalf of the Pool, shall contract with an appropriately licensed and qualified service company, as described under Section 2785.0800 of the Minnesota Rules, for certain services necessary to the Pool's day-to-day operation. The Board may issue a request for proposal with respect to a need for a service company at any time determined necessary by the Board, but no less frequently than once every five (5) years. Upon receipt of responses to a request for proposal, the Board shall evaluate the proposals in accordance with Board established written criteria and select the service company(ies) that, in its judgment, is/are best qualified to provide the required services. Notwithstanding the above, the Board reserves the right to negotiate with any service company that responds and/or to disregard any and all responses.

Section 2. Financial Administrator. The Board shall select one or more financial administrators using a "request for proposal" process determined by the Board. The Board, on behalf of the Pool, shall contract with an appropriately licensed and qualified financial administrator, as described under Section 2785.0800 of the Minnesota Rules, for certain investment and other financial and accounting services necessary to the Pool's operations. The Board may issue a request for proposal with respect to a need for a service company at any time determined necessary by the Board, but no less frequently than once every five (5) years. Upon receipt of responses to a request for proposal, the Board shall evaluate the proposals in accordance with Board established written criteria and select financial administrator(s) that, in its judgment, is/are best qualified to provide the required services. Notwithstanding the above, the Board reserves the right to negotiate with any financial administrator that responds and/or to disregard any and all responses. Pursuant to Section 2785.1500 of

the Minnesota Rules, investments of Pool assets must be made pursuant to an Investment Policy and in accordance with Section 118A.04 of the Minnesota Statutes as described in the Agreement.

ARTICLE V. PARTICIPATION IN THE PLANS AND POOL

Section 1. Joining a Plan. A current Member who is not participating in a Plan offered through the Joint Powers Enterprise, including a Plan funded through the Pool, may apply to participate in that Plan effective as of the first day of that Plan's next Plan Year. The application to participate shall be provided to the Board no later than one-hundred twenty (120) calendar days prior to the proposed participation effective date. The Board may, in its discretion, waive this time period if the Member can establish reasonable cause and the Board determines such shorter time period will not cause harm to the Plan in which the Member wishes to participate. The application to participate in a Plan shall include all information necessary for the Board to determine the Member's ability to satisfy the applicable financial integrity and loss experience standards. The Board shall approve or disapprove the Member's application to participate in a Plan within sixty (60) calendar days of receipt of a complete application.

Section 2. Notice of Assessment Authority. Pursuant to Section 2785.0900 of the Minnesota Rules, with respect to a Plan funded through the Pool, a Member applying to participate must be informed of the possibility of an assessment. The Board or the Minnesota commissioner of commerce may order an assessment against participating Members if necessary to maintain the Pool's sound financial condition.

Section 3. Ceasing Participation in a Plan. A Member may voluntarily terminate participation in a Plan, other than a Plan funded through the Pool, effective as of the close of any Plan Year. A Member may voluntarily terminate participation in a

Plan, including a Plan funded through the Pool, effective as the close of any Plan Year following completion of the Member's initial participation period described in the Agreement. Notice of an intent to terminate participation in a Plan shall be provided to the Board no later than one-hundred twenty (120) calendar days before the effective date of such termination. All terms and conditions of participation in a Plan, as reflected in the Plan document for that Plan, the Agreement, and these Bylaws, shall apply during such notice period. Termination of participation in one Plan made available through the Joint Powers Enterprise shall not affect participation in any other Plan made available through the Joint Powers Enterprise. A Member who has terminated participation in a Plan may not again participate in such Plan (pursuant to Section 1 of this Article) for a period of two (2) years following termination. The Board may, in its discretion, waive this time period if the Member can establish reasonable cause and the Board determines such shorter time period will not cause harm to the Plan in which the Member wishes to participate.

Notwithstanding the foregoing, a Member's attempt to withdraw from a Plan funded through the Pool, shall be void where such withdrawal would jeopardize the financial integrity and stability of the Pool as described in Section 2785.0900 of the Minnesota Rules, including subparts 4 and 6.

Section 4. Required Participation Levels. In order to continue participating in a particular Plan, a Member must maintain a level of participation in that Plan equal to or greater than fifty (50%) percent of "eligible employees" (as that term is defined in the Plan) as of the first day of that Plan's Plan Year. For purposes of determining a Member's compliance with this requirement, the Board may disregard (1) eligible

employees who have waived coverage due to coverage under a spouse's plan, (2) eligible employees who have coverage under another plan as a result of collective bargaining, and (3) any other category of eligible employees deemed appropriate by the Board. If a Member is not satisfying the required participation level in any Plan as of the 120th day prior to the close of the Plan Year, the Board may expel the Member from participation in the Plan, in accordance with Section 7 of this Article, effective as of the close of such Plan Year. Notwithstanding the forgoing, if the Member can demonstrate that as of the first day of the subsequent Plan Year, based upon open enrollment for such Plan Year, the Member will satisfy the requirement participation level, the Board may allow the Member to continue participation in the Plan.

Section 5. Financial Integrity and Loss Experience of the Pool.

(a) Pursuant to Section 2785.1500, the Pool assets must:

- (1) Not be commingled with the assets of any Member;
- (2) Not be loaned to anyone for any reason other than for permitted investments;
- (3) Be used solely for the purposes stated in the Agreement and Bylaws and applicable law; and
- (4) Not be considered, treated, or represented as the property or right of any Member or Participant except as otherwise specifically provided under applicable law.

(b) Sources of Funds. Pursuant to Section 2785.1500 of the Minnesota Rules, the Pool must not borrow money or issue debt, and must not obtain funds through subrogation of Participants' rights. The Pool may collect:

- (1) Debts through bringing legal action;
- (2) Premiums, assessments, and penalties from Members;
- (3) From insurers and indemnitors pursuant to indemnification agreements;
- (4) Dividends, interest, or proceeds from the sale of investments;
- (5) Refunds of excess payments;
- (6) Coordination of benefits with other group programs;
- (7) Money owed to the Pool; and
- (8) Indemnification and special compensation payments relating to workers compensation claims as permitted under applicable law.

(c) Use of Pool Assets. Pursuant to Section 2785.1500 of the Minnesota Rules, assets of the Pool shall be used for losses, expenses, and other costs customarily borne by insurers under conventional insurance policies in Minnesota. In addition, assets of the Pool may be used for any other purpose(s) as permitted or provided by applicable law.

(d) Reserves. Pursuant to Section 2785.1200, the Pool shall establish and maintain reasonable and appropriate Reserves for all reported and unreported incurred losses and for unearned premiums. Such reserves shall be monitored and adjusted according to variations and fluctuations in the pertinent environments (e.g., financial, health care, etc.), including law changes.

(e) Stop Loss Coverage. The Pool shall obtain reasonable and appropriate stop loss insurance as described in the Agreement.

(f) Fidelity Bond. Pursuant to Section 2765.1500 of the Minnesota Rules, all individuals who handle funds, including the Board, shall be covered by a fidelity bond.

(g) Maintenance of Sound Financial Condition. Pursuant to Section 2785.1500 of the Minnesota Rules, the Board shall monitor the Pool's financial condition, including revenues, expenses, and loss development. If necessary, the Board may use any means available to it to restore the sound financial condition of the Pool, including adjusting premium rates, adjusting dividend rates, and assessment to the Members.

Section 6. Financial Integrity and Loss Experience Outside of the Pool. For Plan(s) that are not funded through the Pool, the Board, with the assistance of an appropriate service company and/or financial administrator, shall employ reasonable and appropriate fiscal criteria in valuing, at least annually, the financial soundness of all Plans not funded through the Pool.

Section 7. Expulsion from a Plan. The Board may expel a Member from participation in a Plan upon a Member's: (1) non-performance of its obligations with respect to such Plan as described in the Agreement and these Bylaws, (2) failure to satisfy the required participation leave as described in Section 3 of this Article, (3) failure to satisfy the financial integrity and loss experience standards described in Section 4 of this Article, or (4) other action or failure determined by the Board to be detrimental to the interests of the Plan, and if the Plan is funded through the Pool, the Pool. The procedures for expelling a Member from a Plan shall be the same as the

procedures established in the Agreement for expelling a Member from the Joint Powers Enterprise.

ARTICLE VI. RESPONSIBILITIES OF MEMBERS

In addition to the responsibilities described in the Agreement, Members shall have such other responsibilities as identified from time to time by the Board as being reasonably required for the proper management and maintenance of the Joint Powers Enterprise, including any Plan(s) made available through the Joint Powers Enterprise and the Pool.

ARTICLE VII. NEW MEMBERS

In addition to the conditions described in the Agreement, an employer wishing to become a party to the Agreement (i.e., a Member) must satisfy the following conditions:

(a) Prior to the effective date of the new Member's participation, the Member must execute the Agreement and acknowledge that by doing so, the Member has affirmed its commitment to comply with the Agreement, these Bylaws, and Parts 2785.0100 to 2785.1600 of the Minnesota Rules.

ARTICLE VIII. FINANCIAL MATTERS

Section 1. Dividends. With respect to a Plan funded through the Pool, the Board may declare a dividend, as authorized by the Agreement, and as permitted or provided under applicable law, including Section 2785.1100 of the Minnesota Rules. If declared, the total dividend shall be allocated among the Members currently participating in the Plan with respect to which the dividend is declared. Members (or former Members) who are not participating in the Plan at the time the dividend is declared shall not share in the dividend. The amount of a Member's share of a dividend shall be in the same proportion as the Member's calculated share of reserves as

determined in accordance with the Agreement. Should a dividend be distributed, it shall be the Member's responsibility, in accordance with applicable law, to determine how the dividend shall be used.

Section 2. Contracts, Checks, Drafts, and Other Matters. The Board may authorize any officer or agent, in addition to the officers so authorized by these Bylaws, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the Board, and such authority may be general or confined to specific instances.

All checks, drafts, or orders for the payment of money, notes or other evidences of indebtedness issued in the name of the Board, if any, shall be signed by such person and in such manner as shall from time to time be determined by resolution of the Board. In the absence of such determination by the Board, such instruments shall be signed by the Treasurer and countersigned by the Chairperson of the organization.

ARTICLE IX. AMENDMENTS.

The Board may amend these Bylaws, as from time to time amended or restated, to include or omit any provision which could lawfully be included or omitted at the time such amendment or restatement is adopted. Such action must be taken at a duly noticed meeting with an agenda that specifically states as an item of business the amendment and/or restatement of the Bylaws.

ARTICLE X. FISCAL YEAR.

The fiscal year of the Joint Enterprise, Including the Pool, shall begin on the first day of January and end on the last day of December. The Plan Year for each Plan shall be the fiscal year.

CERTIFICATION

The undersigned, the Secretary of the Board, hereby certifies that the foregoing Bylaws were adopted pursuant to a resolution of the Members effective as of March 31, 2011.

Secretary

Department of Commerce – chronology of events

History of events since 2007:

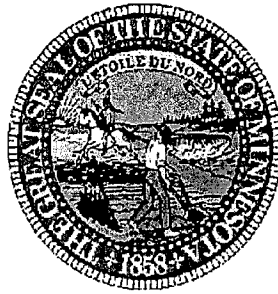
- Duluth has maintained its active and retiree health care plans through an internal Group Health Fund for many years. The DECC, HRA and Airport Authority have co-participated in the Group Health Fund for more than 20 years in order to provide greater health care buying power and access to the Authorities and better health care options and affordability to their employees.
- In 2007 the City transferred \$1.0 million from excess funds in the health care fund to the OPEB trust to fund the City's OPEB retiree health care fund.
- In 2008 the Firefighters filed a grievance regarding the transfer and the arbitrator ordered the City to repay \$500k to the Group Health Fund. The other \$500k was deemed to be filed too late.
- At the same time the Firefighters filed a complaint with the Department of Commerce requesting an investigation and determination that the City is operating a pool and request that DOC direct the City to comply with the pool rules.
- In 2008 the City began a long discussion and negotiation with the DOC over the pool issue.
- On February 1, 2010, in response to the Firefighters' complaint, the DOC commenced formal action against the City and issued a cease and desist order from further transfers from the Group Health Fund to the OPEB trust.
- In July 2010, after months of negotiation, the City reached agreement with the DOC regarding the terms of their final order. That order was issued July 6, 2010.
 - The findings of fact of the DOC were:
 - The City, HRA, DECC and DAA operates a self-insurance pool, the Group Health Fund
 - The Group Health Fund is currently operated under language in the CBAs
 - The City transferred \$1.0 million to OPEB and then transferred \$500k back
 - The DOC concluded the following:
 - The Group Health Fund is a pool subject to DOC regulatory authority and requirements
 - Current operation of the pool does not comply with those requirements
 - No further transfers can be made to the OPEB trust
 - DOC orders Duluth to take the necessary steps to come into compliance with the pool requirements.
- Between July and November 2010 the City worked with the DOC to prepare the acceptable governance documents required to bring the Group Health Fund into compliance Minnesota law and DOC regulations.
- Late December 2010, the DOC finishes its review of the governing documents and issues its Certificate of Authority/Compliance stating the City of Duluth – Joint Insurance Pool has complied with Minnesota law and is now authorized to conduct business as a self-insurance pool. The certificate remains in effect until December 31, 2012 subject to renewal thereafter.

What does this mean?

- The City will take the necessary steps to meet DOC requirements including:
 - A separate governance structure will be set up to operate the health care fund.
 - The internal Group Health Fund will be transferred to an external trust. Its funds will no longer be co-mingled with other City funds.
- A joint powers agreement will be entered into with the participating Authorities to establish the new structure. The JPA lays out the rights and responsibilities of the members (City and Authorities). As a legal agreement, this JPA will require Council approval.
- A trust agreement will provide the financial structure to hold the funds.
- Bylaws will establish operating rules for the pool.
- Employees will see no change in how their benefits are processed and paid.
- The pool and the trust will be subject to DOC oversight, strengthening the integrity of the fund
- Directors to the board who will oversee the operations of the pool will be selected by each of the Members pursuant to applicable DOC rules and regulations.
- The role of the current Labor Management Health Care Committee will become part of a formal labor management structure and continue to include raising issues relating to health care and advising the City administration on possible solutions.

Next steps:

- All the pool findings and governance documents have been shared with the City's Labor Management Health Care Committee.
- The Joint Powers Agreement will require Council consideration and approval.
- January 20, 2011 - A committee of the whole will be requested to discuss and answer any Council questions.
- January 24, 2011 - Administration will bring the Joint Powers Agreement before Council.
- January/February – the Authorities will bring the Joint Powers Agreement before their respective boards for consideration.
- March 31, 2011 – The City of Duluth – Joint Insurance Pool will become effective.



***Certificate of Authority/Compliance
Minnesota Department of Commerce***

Certificate No. 2010-001

Date Licensed in Minnesota: December 31, 2010

State/Country of Domicile: MINNESOTA

CITY OF DULUTH – JOINT INSURANCE POOL

has complied with all the requirements and laws of the State of Minnesota and is hereby authorized to transact the business of a political subdivision self-insurance pool under Minnesota Statutes Chapter 471 and Minnesota Rules Chapter 2785.

This certificate shall remain in effect until December 31, 2012 or until suspended, revoked, or otherwise legally terminated.

IN TESTIMONY WHEREOF, I have
hereunto set my hand at my office in the
City of St. Paul, Minnesota.

December 21, 2010

A handwritten signature in cursive script, appearing to read "Glenn Wilson".

Commissioner of Commerce